COVID-10 Screening Questions

Name: _____ Date: _____

Please answer the following questions to the best of your knowledge.

1. Have you or anyone in your household had any of the following symptoms in the last 14 days that are NOT common to you: ☐ YES ☐ NO
   - Sore throat
   - Cough
   - Chills
   - Body aches for unknown reasons
   - Shortness of breath for unknown reasons
   - Loss smell/loss of taste
   - Fever at or greater than 100 degrees Fahrenheit
2. Are you currently experiencing any of the above symptoms that are not common to you? ☐ YES ☐ NO
3. Have you or anyone in your household tested POSITIVE for COVID-19 in the last 14 days? ☐ YES ☐ NO
4. Do you have any reason to believe you or anyone in your household has been exposed to or acquired COVID-19 within the last 14 days? ☐ YES ☐ NO
5. To the best of your knowledge have you been in close proximity to any individual who tested positive for COVID-19 within the last 14 days? ☐ YES ☐ NO

IF YOU HAVE NOT BEEN FULLY VACCINATED:

6. Personal protective equipment is required for your examination (mask covering your nose and mouth). Are you willing to wear PPE for the duration of your evaluation? ☐ YES ☐ NO