Patient Pre-Screening Questionnaire (Phone or In Person)

Patient Name:_____ Age:_____

1) Do you have any of the following symptoms:

☐ Fever above 100.3F	Yes	No
☐ Persistent Cough	Yes	No
☐ Fatigue and Body Aches	Yes	No
☐ Unexplained Diarrhea	Yes	No
☐ Pink Eye (Conjunctivitis)	Yes	No
☐ Sore Throat	Yes	No
☐ Loss of Sense of Smell +/- Taste	Yes	No
☐ Headaches (beyond the norm)	Yes	No

2) Any sick Contacts within the last 2 weeks Yes No

3) Any travel via public transportation in the last 14 days (plane, train, bus, boat, etc...) Yes No

4) Medical Comorbidities:

☐ Hypertension (High Blood Pressure)	Yes	No
☐ Diabetes	Yes	No
☐ Kidney Disease	Yes	No
☐ Liver Disease	Yes	No
☐ Immunosuppressed State	Yes	No

5) Clinician's Decision:_____

_____

_____

*Recommendation: Any positive response for symptoms and/or those at risk should be deferred for a minimum of two weeks and referred for potential testing