"Specialists in Preventative Medicine for over 55 years"
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Covid – 19 Screening Form

Name:_____DOB:_____Sex: ☐ Male ☐ Female

US Resident: ☐ Yes ☐ No

If no, country of residence: _____

Symptoms

Elevated temperature greater than 100 F degrees:	☐ Yes	☐ No			
Suspected fever/elevated temperature:	☐ Yes	☐ No			
Cough:	☐ Yes	☐ No	Sudden loss of smell or taste:	☐ Yes	☐ No
Sore throat:	☐ Yes	☐ No			
Shortness of breath at rest:	☐ Yes	☐ No	Bluish lips or face:	☐ Yes	☐ No
Chills:	☐ Yes	☐ No	Headache:	☐ Yes	☐ No
Muscle aches:	☐ Yes	☐ No	Vomiting:	☐ Yes	☐ No
Abdominal pain:	☐ Yes	☐ No	Diarrhea:	☐ Yes	☐ No

Travel

China:	☐ Yes	☐ No	Italy:	☐ Yes	☐ No	Middle East:	☐ Yes	☐ No

Other US cities or foreign countries:_____

Dates of travel:_____Return home date:_____

Exposure

Have you been exposed through close personal contact with an individual who has been diagnosed and has tested positive or who is under investigation for the Corona Virus? ☐ Yes ☐ No

If yes, who? _____

Have you been a healthcare provider for an individual who has been diagnosed with or who is under investigation for Corona Virus infection? ☐ Yes ☐ No

Other Medical Conditions: