COVID-19/FLU SEASON PATIENT SCREENING QUESTIONAIRE

***Indicate Yes or No and provide relevant comments.**

For any "Yes" answers to questions 1-6, please reschedule the event until after 14 days.

Patient Name: _____ Date: _____

Phone Number: _____

Screening Questions	Pre-Event		Day of Event		Comments
1. Do you have a fever, or have you felt feverish recently?	Yes	No	Yes	No	
2. Do you have cough, sore throat or shortness of breath?	Yes	No	Yes	No	
3. Do you have any recent loss of state or smell?	Yes	No	Yes	No	
4. Have you been diagnosed with COVID-19 in the last 14 days?	Yes	No	Yes	No	
5. Are you in contact with anyone who has been confirmed to be COVID-19 positive in the last 14 days?	Yes	No	Yes	No	
6. Have you been tested for COVID-19? If yes, what was the result in the last 14 days?	Yes	No	Yes	No	
7. Have you been vaccinated for COVID-19? When?	Yes	No	Yes	No	Date: