COVID-SCREENING QUESTIONNAIRE

Vascular Solutions of North Carolina

Patient Name: _____
Temperature : _____
Date : _____

☐ YES ☐ NO 1. Have you traveled outside the USA in the past 14 days?

☐ YES ☐ NO 2. Have you traveled within the USA in the past 14 days?

☐ YES ☐ NO 3. Have you been in contact with someone that has tested positive for COVID-19?

☐ YES ☐ NO 4. Have you been tested for COVID-19? If yes, what was the result? _____

☐ YES ☐ NO 5. Do you currently have a fever or respiratory symptoms such as cough or shortness of breath?

☐ YES ☐ NO 6. Do you have chills or repeated shaking with 'chills'?

☐ YES ☐ NO 7. Do you have any other flu-like symptoms?

☐ YES ☐ NO 8. Have you been diagnosed with COVID-19? If yes, when?
_____

☐ YES ☐ NO 9. Have you had any recent diarrhea or loss of taste or smell?

Signature of Patient: _____ Date: _____