**Copy of YCMC COVID-19 Patient Screening Questionnaire**

COVID-19 PATIENT SCREENING QUESTIONNAIRE

All questions marked with an asterisk (\*) are required and must be completed before you are able to submit the survey.

Patient Name

Date of Birth

Are you currently experiencing, or have experienced in the past 14 days, any of the following symptoms?

**Fever or feeling feverish?** (choose one)

 Yes  No

**Cough** (choose one)

 Yes  No

**Shortness of Breath or difficulty breathing** (choose one)

 Yes  No

**Sore Throat** (choose one)

 Yes  No

**New loss of taste or smell** (choose one)

 Yes  No

**Chills** (choose one)

 Yes  No

**Head or muscle aches** (choose one)

 Yes  No

**Nausea, diarrhea, vomiting** (choose one)

 Yes  No

In the past 14 days, have you been in close proximity to anyone who was experiencing any of the above symptoms? (choose one)

 Yes  No

In the past 14 days, have you been in close proximity to anyone who has tested positive for COVID-19? (choose one)

 Yes  No

**Have you been tested for COVID-19** (choose one)

 Yes  No

If yes, what was the result?

List the date of test

In the past 14 days, have you been on a commercial flight or traveled outside the United States (choose one)

 Yes  No