Patient Name: _____ Date: _____

Pre-Screening ☐ In-Office Screening ☐

Wellness Screening Checklist

SYMPTOM WELLNESS CHECK:

circle answer

1. Have you experienced any of the following symptoms within the last 14 days?
   - Fever or feeling feverish ..... Yes No
   - New cough ..... Yes No
   - Shortness of breath ..... Yes No
   - Flu-like symptoms such as fatigue, nausea, diarrhea? Chills? Repeated shaking with chills? Muscle pain? Headache? Sore throat? New loss of taste or smell? Rash? ..... Yes No

     Please circle all that apply.
2. Have you been diagnosed or suspected of having Coronavirus or COVID-19? ..... Yes No
   - If yes, when? _____
3. Have you been tested for Coronavirus or COVID-19? ..... Yes No
   - If tested, was testing performed by nasal swab or blood test? _____
   - If tested, did you test: Positive or Negative _____
   - Have you had an antibody test for Coronavirus? ..... Yes No
   - If tested, did you test: Positive or Negative _____
   - If known, was the test for IgM or IgG antibodies? _____

FAMILY AND CLOSE CONTACTS:

circle answer

1. Are any of your family members or immediate/close contacts currently sick or experiencing fever, cough, shortness of breath, or flu-like symptoms (sore throat, muscle aches, fatigue, nausea and diarrhea)? ..... Yes No
2. Have any of your family members or immediate/close contacts been diagnosed with Coronavirus or COVID-19? ..... Yes No
   - If yes, when? _____

RECENT TRAVEL:

circle answer

1. Have you recently travelled in the U.S. or internationally? ..... Yes No
   - If yes, where and when? _____
2. Have any of your family members recently travelled in the U.S or internationally? ..... Yes No
   - If yes, where and when? _____

NOTES: