Mid-Atlantic Medicine COVID Screening Form

Patient Name: Date:

Do you have a fever or have you felt hot or feverish recently (14-21) days?

YES NO

Are you having shortness of breath or other difficulties breathing?

YES NO

Do you have a cough?

YES NO

Any other flu-like symptoms, such as upset stomach, headache, or fatigue?

YES NO

Have you experienced recent loss of taste or smell?

YES NO

Are you in contact with any confirmed COVID-19 positive or COVID-19 symptom patient?

YES NO

(The CDC recommends that patients who are well should still consider postponing elective treatment if they have a family member at home with COVID-19.)

For Staff Only:

Temperature:
Pulse Ox: