Pre-Visit: COVID-19 Screening Questions

- **Have You Experienced a Fever (over 98.6 F / 37 C) or felt Chills in the past 14 days?**

[YES or NO, **WHAT TEMP?**]

- **Have You or anyone in Your Household Travelled Outside the state in the past 14 days?**

[YES or NO, **LOCATIONS**]

- **Have You been in Direct Contact with anyone Diagnosed with COVID19 within the past 14 days?**

[YES or NO, **DETAILS**]

- **Have You been Tested Positive or otherwise Diagnosed as Having COVID19?**

[YES or NO, **DETAILS**]

- **Have you experienced a Cough in the past 14 days?**

[YES or NO, **DETAILS**]

- **Have you experienced Shortness of Breath or Difficulty Breathing in the past 14 days?**

[YES or NO, **DETAILS**]

- **Have You experienced a Sore Throat in the past 14 days?**

[YES or NO, **DETAILS**]

- **Have You experienced Inexplicable Muscle Pain in the past 14 days?**

[YES or NO, **DETAILS**]

- **Have You lost your Sense of Smell or Taste in the past 14 days?**

[YES or NO, **DETAILS**]