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COVID SCREENING FORM

DATE:
NAME:
DATE OF BIRTH (MM/DD/YEAR):
COVID VACCINATION DATE: CIRCLE: Pfizer Moderna J & J Janssen
KNOWN COVID CONTACT? YES / NO TESTED FOR COVID? YES / NO
COVID RESULTS? + / -
CONGESTED? YES / NO
FEVER? YES / NO
HOW DID YOU TREAT YOUR FEVER?
SHORTNESS OF BREATH? YES / NO IF YES, PLEASE DESCRIBE:
SORE THROAT? YES / NO
COUGH? YES / NO
PRODUCTIVE COUGH? YES / NO IF YES, PLEASE DESCRIBE:
BODY ACHES? YES / NO
RASH? YES / NO
LOSS OF SMELL & / OR TASTE? YES / NO
DIARRHEA? YES / NO
DATE OF LAST COVID TEST (MM/DD/YEAR):
RECENT TRAVEL? YES / NO
RECENT TRAVEL LOCATIONS:
DATE OF ONSET:
LENGTH OF ILLNESS:
NOTES: