Provider: Sasipha "Kate" Pahamark (Family Nurse Practitioner)

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# COVID-19 TESTING SCREENING QUESTIONNAIRE

1. Do you currently have any of the following symptoms? *(Select all that apply)*

   ☐ Fever less than 102°F or feeling feverish ☐ Chills

   ☐ Repeated shaking with chills ☐ New or worsening cough

   ☐ Sore throat ☐ Shortness of breath or difficulty breathing (not severe)

   ☐ Muscle pain/body aches ☐ Headache ☐ New loss of taste or smell

   ☐ Nausea, vomiting or diarrhea ☐ None of the above

2. In the last 14 days, have you had contact with someone who's been diagnosed with (or is presumed to have) COVID-19?

   ☐ Yes ☐ No

3. In the last 2 weeks, have you been in contact (within 6 ft. of the person for a prolonged period of time or been coughed on) with someone who is sick but has not been diagnosed with COVID-19?

   ☐ Yes ☐ No

4. In the last 2 weeks, have you had any of the following exposures? *(Select all that apply)*

   ☐ International travel

   ☐ Have visited an area outside Oklahoma. If so, where? ___________________________

   ☐ None of these

5. Do any of the following describe your work setting? *(Select all that apply)*

   ☐ Healthcare Facility: I work in a clinic, hospital, nursing home, or senior care facility or other healthcare facility

   ☐ First Responder: I am a first responder, such as an ambulance worker, law enforcement officer, or firefighter

   ☐ None of the above

6. Do you have any of the following conditions? (Select all that apply)

☐ Chronic lung disease or moderate to severe asthma

☐ Serious heart condition (including high blood pressure, previous heart attacks, heart failure, etc.)

☐ I have a neurologic condition that affects my ability to cough (e.g., had a stroke)

☐ Condition that can cause a person to be immunocompromised (including cancer treatment, smoking, bone marrow or organ transplant, immune deficiencies, HIV positive, prolonged use of corticosteroids and other immune weakening medications)

☐ I smoke

☐ I am very overweight or obese

☐ Diabetes

☐ Chronic kidney disease or undergoing dialysis

☐ Liver disease

☐ None of the above

7. Are you currently pregnant?

☐ Yes ☐ No ☐ Does not apply to me

8. Have you ever had a COVID-19 test?

☐ Yes ☐ No If yes, when? ________________________

9. Have you received a COVID-19 vaccine?

☐ Yes ☐ No If yes, when? ________________________

Patient Name: ______________________________________ Date: ______________________

(Please print clearly)

Patient Signature: ___________________________________ Relationship: ________________

(Parent or Legal Guardian, if minor)