COVID Screening Form
(Please initial after each question)

Name:_____ Temp:_____

1) Have you currently have any symptoms of COVID-19 including fever, headaches, cough, shortness of breath, loss of smell/taste?

- ❑ Yes If yes, how long, treatment?_____
- ❑ No

2) Have you recently been around any individual who has had COVID symptoms or tested positive for COVID?

- ❑ Yes
- ❑ No

If yes, how long since direct contact with them?_____

3) In the past 2 weeks have you been in any high risk group settings?

- ❑ Yes
- ❑ No

If Yes explain:_____

5) Have you had a COVID-19 vaccination or Booster?

- ❑ Yes: Initial Vaccination Which one?_____
- ❑ Yes: Booster 1 When?:_____
- ❑ Yes: Booster 2 When?:_____
- ❑ No Vaccination or Booster

6) Have you had the COVID virus?

- ❑ Yes When?:_____
- ❑ No

7) Have you completed a new medical history with updated medication list, allergies, or issues? (If No, please provide update)

- ❑ Yes ☐ No

Patient Signature:_____Date:_____

Witness:_____Date:_____