Covid-19 Patient Screening Form

Patient Name:_____Date:_____

Temperature:_____

Do you have shortness of breath or difficulty breathing? Y / N

Have you had a fever in the past 14 days? Y / N

Do you have a cough? Y / N

Are you having any flu like symptoms', headache or fatigue? Y / N

Have you experienced recent loss of taste or smell? Y / N

Have you had contact that you are aware of with a confirmed Covid-19 positive patient? Y / N

Have you traveled in the past 14 days? Y / N