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COVID-19 Screening Form ... Please fill out this form and email to drviani@gmail.com or mail to the above address.

Patient's name: _____

Date: _____ **Date:** _____

PREAPPOINTMENT CHECK **IN-OFFICE VISIT**

YES ☐ NO ☐

1. Have you previously been diagnosed with COVID-19, or do you think you've had/have COVID-19?

YES ☐ NO ☐

(If NO to question 1, skip to question 5)

2. If YES, when and how were you confirmed positive?

☐ I think I had it.
☐ I had a positive nasal swab test.
☐ I had a positive blood test.
☐ I had a positive saliva test.
☐ I currently have symptoms and am waiting for a test.

3. If you have had COVID-19, how were you confirmed negative?

☐ I was diagnosed negative by a nasal swab test. How many times? How far apart? _____
☐ I show antibodies to COVID-19 with a blood test.
☐ My doctor said I no longer have it because I don't have any symptoms.
☐ I don't have any symptoms, so I don't have it.

4. If you have had COVID-19, when were you confirmed negative?

☐ 24 hours ago ☐ today ☐ 10 days after testing

5. Do you currently have (or have you experienced) any of the following symptoms in the past 21 days:

Fever	YES ☐ NO ☐	YES ☐ NO ☐
	If fever, how did you measure it? _____	
Fatigue (feeling tired)	YES ☐ NO ☐	YES ☐ NO ☐
Altered or loss of taste/smell	YES ☐ NO ☐	YES ☐ NO ☐
Dry cough	YES ☐ NO ☐	YES ☐ NO ☐
Trouble breathing	YES ☐ NO ☐	YES ☐ NO ☐
Shortness of breath, difficulty breathing, chest tightness	YES ☐ NO ☐	YES ☐ NO ☐
Confusion	YES ☐ NO ☐	YES ☐ NO ☐
Blueish lips or face	YES ☐ NO ☐	YES ☐ NO ☐
Chills/repeated shaking with chills	YES ☐ NO ☐	YES ☐ NO ☐
Muscle pain	YES ☐ NO ☐	YES ☐ NO ☐
Headache or sore throat	YES ☐ NO ☐	YES ☐ NO ☐

Any other flu-like symptoms YES ☐ NO ☐ PLEASE LIST YES ☐ NO ☐ PLEASE LIST

GI upset or diarrhea YES ☐ NO ☐ YES ☐ NO ☐

6. Are you in contact with anyone who has been sick and/or confirmed to be COVID-19–positive?

YES ☐ NO ☐ YES ☐ NO ☐

7. In the past 14 days have you traveled to any regions affected by COVID-19?

YES ☐ NO ☐ YES ☐ NO ☐

Some medical conditions have been associated with more severe COVID-19 disease. The following questions are an attempt to determine your risk:

8. Are you over age 65? YES ☐ NO ☐ YES ☐ NO ☐

9. Do you have high blood pressure? YES ☐ NO ☐ YES ☐ NO ☐

If you have high blood pressure, is it controlled? YES ☐ NO ☐ YES ☐ NO ☐

10. Do you have diabetes? YES ☐ NO ☐ YES ☐ NO ☐

11. Are you overweight? YES ☐ NO ☐ NO ANSWER ☐ YES ☐ NO ☐ NO ANSWER ☐

12. Do you have respiratory problems? YES ☐ NO ☐ YES ☐ NO ☐

13. Do you have any autoimmune disorders?

YES ☐ NO ☐ YES ☐ NO ☐

14. Are there any other conditions you would like to report?