

PATIENT PRE-SCREENING QUESTIONNAIRE

We appreciate your cooperation and patience in helping to keep our patients and staff safe and healthy.

*Have you traveled outside the U.S in the past 30 days? YES NO

If yes, where? _____

*Have you traveled to another state, by train, plane, bus or car in the past 30 days?

YES NO If yes, where? _____

*Are you experiencing any of these symptoms today or have experienced in the past 30 days?

Fever YES NO

Coughing YES NO

Sore Throat YES NO

Difficulty Breathing YES NO

Runny nose YES NO

*Have you been in personal contact with a person in the past 30 days who has been:
-infected with or exposed to the Coronavirus?
-who traveled to an area with widespread transmission?

YES NO

• Are you being currently tested for or awaiting results for COVID-19?

YES NO

If yes, please explain _____

Print Name: _____ Signature _____

Date: _____

**** If you answered YES to any question please call our office at (508) 754-5891