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COVID-19 Patient Screening Questionnaire to Determine a Vulnerable Individual

1) Do you have a fever or have you experienced a fever within the past 14 days? Y / N

2) Does anyone close to you have a fever or have they experienced a fever in the past 14 days? Y / N

3) Have you or anyone close to you experienced a recent onset of respiratory problems, such as a cough, or difficulty in breathing within the past 14 days? Y / N

4) Have you or anyone close to you experienced flu-like symptoms within the past 14 days such as:

Y / N: Cough – wet or dry
Y / N: Fever
Y / N: Shortness of Breath
Y / N: Sore Throat
Y / N: Muscle/Body Aches
Y / N: Nausea/Vomiting
Y / N: Fatigue
Y / N: A recent lack of taste or smell

5) Have you, or anyone you have come into contact with traveled out of state within the last 14 days? Y / N

6) Have you, or anyone you have come into contact with, traveled outside of the country in the last 21 days? Y / N

7) Have you come into contact with anyone who has tested positive for COVID-19? Y / N

8) Have you been tested for COVID-19, with either a positive or negative result or are you awaiting results? Y / N

9) Do you take immune-suppressing medication or steroids? Y / N

10) Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders? Y / N

11)Have you been diagnosed or treated for cancer in the past 12 months? Y / N

12) Do you currently smoke or vape or have you stopped those activities within the past 2 years? Y / N

_____ _____
Name Signature of Staff Date

_____
Signature Date Temperature: _____