COVID-19 SCREENING FORM
PATIENT NAME:_____
DATE FILLING OUT FORM(no more then 2 days prior to your appointment)_____
DATE OF YOUR APPOINTMENT_____

DO YOU HAVE ANY SYMPTOMS THAT ARE SIMILAR TO THOSE OF COVID-19? (check all that apply)

- FATIGUE___
- ALTERED TASTE/SMELL___
- DRY COUGH___
- TROUBLE BREATHING___
- CONFUSION___
- BLUEISH LIPS/FACE___
- CHILLS___
- MUSCLE PAIN___
- HEADACHE OR SORE THROAT___
- ANY OTHER FLU-LIKE SYMPTOMS___
- GI UPSET OR DIARRHEA___

HAVE YOU BEEN TESTED FOR COVID-19?___
IF YES, WHY_____WHEN_____
RESULT +_____ -_____
IF +, DID YOU SELF QUARANTINE
FOR 14 DAYS?____
HAVE YOU TESTED NEGATIVE SINCE YOU QUARANTINED?____
HAVE YOU TRAVELLED BY AIRPLANE IN THE PAST 2 WEEKS?_____
DO YOU TRAVEL OUTSIDE OF DUTCHESS COUNTY FOR WORK/LEISURE?____
HAVE YOU BEEN IN CONTACT WITH ANYONE WHO HAS BEEN SICK AND/OR CONFIRMED TO BE COVID-19 POSITIVE?_____
SOME MEDICAL CONDITIONS HAVE BEEN ASSOCIATED WITH MORE SEVERE COVID-19 DISEASE. THE FOLLOWING QUESTIONS ARE AN ATTEMPT TO DETERMINE YOUR RISK.

- ARE YOU OVER AGE 65?____
- DO YOU HAVE HIGH BLOOD PRESSURE?___
  IF YES, IS IT CONTROLLED?____
- DO YOU HAVE DIABETES?____
- DO YOU HAVE RESPIRATORY PROBLEMS?____
- DO YOU HAVE ANY AUTOIMMUNE DISORDERS?____

SIGNATURE_____