# COVID-19 Patient Screening Form

**Patient Name_____**

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| 1. Are you over 60 years of age? | YES/NO |
| 2. Do you have a pre-existing condition such as heart disease, diabetes, kidney disease or an autoimmune disorder? | YES/NO |
| 3. Are you experiencing shortness of breath or trouble breathing? | YES/NO |
| 4. Do you have a temperature of 100.4 F or higher? | YES/NO |
| 5. Are you experiencing a sore throat? | YES/NO |
| 6. Are you coughing? | YES/NO |
| 7. Are you experiencing shaking or chills? | YES/NO |
| 8. Do you have muscle aches? | YES/NO |
| 9. Are you experiencing gastrointestinal issues? | YES/NO |
| 10. Have you noticed a loss of smell or taste? | YES/NO |
| 11. Have you had contact with a known or suspected COVID-19 positive person? | YES/NO |
| 12. In the last 14 days, have you travelled to an area that has a high incidence of COVID-19? | YES/NO |