COVID-19 SCREENING FORM

ALL VISITORS AND PATIENTS MUST COMPLETE THIS FORM and GIVE IT DIRECTLY TO THE NURSE.

DATE: _____ SEX: M F

NAME: _____ DATE OF BIRTH: _____

1. Do you have a fever? Y N
2. Do you have a cough? Y N
3. Do you have Shortness of Breath? Y N
4. Lost sense of smell? Y N
5. Have you traveled in the past 14 days? Y N

   Where: _____
   Airplane: Y N

   Cruise: Y N
6. Have you attended any large gatherings within the last 14 days? Y N
7. Have you been in close contact with:
   - Anyone Quarantined? Y N
   - Anyone that has been tested for COVID-19: Y N
   - Anyone that tested positive for COVID-19: Y N

Signature: _____