

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

Pre-Screening

In-Office Screening

## Wellness Screening Checklist

### SYMPTOM WELLNESS CHECK:

circle answer

1. Have you experienced any of the following symptoms within the last 14 days?

- |   |     |    |
|---|-----|----|
| • Fever or feeling feverish .....   | Yes | No |
| • New cough .....   | Yes | No |
| • Shortness of breath .....   | Yes | No |
| • Flu-like symptoms such as fatigue, nausea, diarrhea? Chills? Repeated shaking with chills? Muscle pain? Headache? Sore throat? New loss of taste or smell? Rash?..... | Yes | No |
- Please circle all that apply.

2. Have you been diagnosed or suspected of having Coronavirus or COVID-19?..... Yes No

- If yes, when? \_\_\_\_\_

3. Have you been tested for Coronavirus or COVID-19? ..... Yes No

- If tested, was testing performed by nasal swab or blood test? \_\_\_\_\_
- If tested, did you test: Positive or Negative \_\_\_\_\_
- Have you had an antibody test for Coronavirus? ..... Yes No
- If tested, did you test: Positive or Negative \_\_\_\_\_
- If known, was the test for IgM or IgG antibodies? \_\_\_\_\_

### FAMILY AND CLOSE CONTACTS:

circle answer

1. Are any of your family members or immediate/close contacts currently sick or experiencing fever, cough, shortness of breath, or flu-like symptoms (sore throat, muscle aches, fatigue, nausea and diarrhea)?..... Yes No

2. Have any of your family members or immediate/close contacts been diagnosed with Coronavirus or COVID-19?..... Yes No

- If yes, when? \_\_\_\_\_

### RECENT TRAVEL:

circle answer

1. Have you recently travelled in the U.S. or internationally? ..... Yes No

- If yes, where and when? \_\_\_\_\_

2. Have any of your family members recently travelled in the U.S or internationally? ..... Yes No

- If yes, where and when? \_\_\_\_\_

### NOTES: