COVID-19 Patient Pre-Screening Form

	YES	NO
1. **Do you have a fever or above-normal temperature (>100.4 F)?**	☐	☐
2. **Are you experiencing shortness of breath or having trouble breathing?**	☐	☐
3. **Do you have a dry cough?**	☐	☐
4. **Do you have a runny nose?**	☐	☐
5. **Do you have a sore throat?**	☐	☐
6. **Do you have a headache?**	☐	☐
7. **Have you recently lost or had a reduction in your sense of smell or taste?**	☐	☐
8. **Are you experiencing chills or repeated shaking with chills?**	☐	☐
9. **Do you have unexplained muscle pain?**	☐	☐
10. **Even if you don't currently have any of the above symptoms, have you experienced any of these symptoms in the last 14 days?**	☐	☐
11. **Have you been in contact with someone who has tested positive for COVID-19 in the last 14 days?**	☐	☐
12. **Have you been tested for COVID-19 in the last 14 days?**	☐	☐
13. **Have you traveled more than 100 miles from your home in the last 14 days?**	☐	☐