Julie L. Henry-Kelly, MD

COVID-19 SCREENING QUESTIONS

Name: _____ Date: _____

1)	Have you tested positive for COVID-19 in the past 21 days?	Yes ▢ No ▢
2)	Have you been exposted (within 6 feet for more than 10 minutes without a face mask) to a confirmed diagnosed COVID-19 person in the past 14 days?	Yes ▢ No ▢
3)	Do you have a fever greater than 100.4F?	Yes ▢ No ▢
4)	Do you have a NEW or abnormal cough?	Yes ▢ No ▢
5)	Do you have NEW difficulty breathing, shortness of breath or difficulty speaking?	Yes ▢ No ▢
6)	Have you had muscle pain, headache, fatigue or loss of appetite?	Yes ▢ No ▢
7)	Have you had a sore throat, runny nose or congestion?	Yes ▢ No ▢
8)	Have you had NEW nausea, vomiting or diarrhea?	Yes ▢ No ▢
9)	Have you had NEW loss of taste or smell?	Yes ▢ No ▢
10)	Do you have a known health condition that may be causing any symptoms you are experiencing?	Yes ▢ No ▢

UPDATED 12/11/20