COVID-19 SCREENING QUESTIONNAIRE

Patient Name: _____ Date: _____

Age: _____ Sex: ❑ M ❑ F

1. Are you experiencing any cold or flu-like symptoms such as **fever, cough, shortness of breath, or sore throat**? ❑ YES ❑ NO

2. Have any of your family members or friends that you have been in contact with experienced any cold or flu-like symptoms such as **fever, cough, shortness of breath, or sore throat**? ❑ YES ❑ NO

3. Have you been in contact with anyone that is suspected or confirmed to have contracted COVID-19 also known as Coronavirus? ❑ YES ❑ NO
   If you answered YES to the question above please answer the following questions:

   a) When was the last time you were in the presence of that person? _____
   b) Do you live with that person? ❑ YES ❑ NO

4. Have you been out of the country in the last two weeks? ❑ YES ❑ NO
   If YES, which country(ies) have you visited? _____

5. Have you been out of Kern County in the last two weeks? ❑ YES ❑ NO
   If YES, where have you visited? _____

6. What is the purpose of your visit today? _____

To be completed by screener:

Patient's Temperature: _____ ^{0}F

Has patient coughed or shown any flu like symptoms during the screening? ❑ YES ❑ NO

❑ Instruct patient not to bring anyone else with them inside the office. If the patient is a minor, only one parent can accompany the patient.

❑ Ask patient to have others, such as their ride, to please wait in their vehicles as we want to limit the amount of people in the office.