Patient Screening Form

1. Do you have any of the following respiratory symptoms: Fever, Sore Throat, Cough, Shortness of Breath? ☐ Yes ☐ No

2. Have you recently lost your sense of smell or taste? ☐ Yes ☐ No

3. Do you have any GI symptoms, Diarrhea, or Nausea? ☐ Yes ☐ No

4. Even if you don't currently have any of the above symptoms, have you experienced any of these symptoms in the last 14 days? ☐ Yes ☐ No

5. Have you been in contact with someone who has tested positive for COVID-19 in the last 14 days? ☐ Yes ☐ No

6. Have you traveled outside the United States by air or cruise ship in the past 14 days? ☐ Yes ☐ No

7. Have you traveled within the United States by air, bus or train within the past 14 days? ☐ Yes ☐ No

Patient Name:______________________________ Date:________________