Patient name _____ Date of birth_____

Date of Visit_____ Cell phone _____

Email _____

COVID-19 PATIENT SCREENING QUESTIONNAIRE

Insurance YES____ NO____

*Indicate Yes or No and provide relevant comments.

MD_____

Screening Questions	YES	NO	Comments / additional note
Do you have a fever, or have you felt feverish recently?			
Do you have a cough?			
Areyouhavingshortnessofbreathoranydifficulty breathing?			
Do you have chills or repeated shaking with chills?			
Do you have any muscle pain?			
Do you have any recent onset of headache or sore throat?			
Do you have any other flu-like symptoms?			
Do you have any recent loss of taste or smell?			
Have you experienced any recent GI upset or diarrhea?			
Areyouincurrently needing to see a physician on staff now?			
IF you Answered YES to any of this above questions, please see the MD on staff – will be checked in with MD consult requested	Any questions answer yes must be seen by MD for proper ordering of Rapid Nasal & PCR & antibody	Further Treatment and diagnosis may be needed to make sure Covid related illness VS other kind of illness	Front Desk with check in with MD consult – for proper diagnosis and treatment
*Do you need to get PCR testing for TRAVEL outside the USA? And is this a STAT result?			Please list the date that you need your PCR test by:
Have you been diagnosed with COVID-19? If yes, when?			What was the treatment for your covid + condition:
Do you have Diabetes?			
Do you have a Primary Care physician ? Please list?			Name of MD:
Do you have Depression/ Anxiety/ Stress. Would you like to have our staff to email / call you about Behavior Treatment options			

Recommendation: _____Rapid Nasal Antigen _____PCR Nasal _____Antibody

Patient name _____ Date of birth_____

Date of Visit_____ Cell phone _____

COVID-19 PATIENT SCREENING QUESTIONNAIRE

How often have you experienced the following activities over the last 2 weeks?		Not at all	Rare, less than a day or two	Several days	More than 7 days	Nearly every day over the last 2 weeks
1. I felt dizzy, lightheaded, or faint, when I read or listened to news about the coronavirus.		0	1	2	3	4
2. I had trouble falling or staying asleep because I was thinking about the coronavirus.		0	1	2	3	4
3. I felt paralyzed or frozen when I thought about or was exposed to information about the coronavirus.		0	1	2	3	4
4. I lost interest in eating when I thought about or was exposed to information about the coronavirus.		0	1	2	3	4
5. I felt nauseous or had stomach problems when I thought about or was exposed to information about the coronavirus.		0	1	2	3	4
Column Totals		_____+	_____+	_____+	_____+	_____=
				Total Score _____		

Updated 08/22/2020