COVID-19 SCREENING QUESTIONNAIRE

FOR PATIENTS RECEIVING VACCINATIONS

Patient Name: ____________________________________ Date: ___________

	YES	NO
Do you have a fever, or have you felt feverish lately?		
Do you have a cough?		
Are you having shortness of breath or any difficulty 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?		
Are you in contact with anyone who has been confirmed to be COVID-19 positive?		
Have you traveled in the past 14 days to any regions affected by COVID-19?		
Have you been tested for COVID-19? If yes, what was the result? When?		

Temperature: ________________________