**COVID-19 Screening Form**

**PREAPPOINTMENT CHECK IN-OFFICE VISIT**

**Patient’s name:**

**Date Of Birth:**

**Patient code:**

**\*\* Have you previously been diagnosed with COVID-19, or do you think you’ve had/have COVID-19?** YES NO

***(If NO to question 1, skip to question 4)***

1. If YES, when and how were you confirmed positive?

* *I think I had it.*
* *I had a positive nasal swab test.*
* *I had a positive blood test.*
* *I had a positive saliva test.*
* *I currently have symptoms and am waiting for a test.*

1. If you have had COVID-19, how were you confirmed negative?

* *I was diagnosed negative by a nasal swab test. How many times? How far apart?*
* *I show antibodies to COVID-19 with a blood test.*
* *My doctor said I no longer have it because I don’t have any symptoms.*

*I don’t have any symptoms, so I don’t have it.*

1. If you have had COVID-19, when were you confirmed negative?

24 hours ago today 10 days after testing

1. Have you experienced any of the following symptoms in the past 21 days:

Fever YES NO

*If fever, how did you measure it?*

Fatigue (feeling tired) YES NO

Altered or loss of taste/smell YES NO

Dry cough YES NO

Trouble breathing YES NO

Shortness of breath, difficulty YES NO

breathing, chest tightness YES NO

Confusion YES NO

Blueish lips or face YES NO

Chills/repeated shaking with chills YES NO

Muscle pain YES NO

Headache or sore throat YES NO

Any other flu-like symptoms YES NO

If Yes, PLEASE LIST:

GI upset or diarrhoea YES NO

1. Are you in contact with anyone who has been sick and/or confirmed to be COVID-19–positive?

YES NO

1. In the past 14 days have you travelled to any regions affected by COVID-19?

YES NO

*Some medical conditions have been associated with more severe COVID-19 disease. The following questions are an attempt to determine your risk:*

1. Are you over age 65? YES NO
2. Do you have high blood pressure? YES NO
3. *If you have high blood pressure, is it controlled?* YES NO
4. Do you have diabetes? YES NO
5. Are you overweight? YES NO
6. Do you have respiratory problems? YES NO
7. Do you have any autoimmune disorders? YES NO
8. Are there any other conditions you would like to report? YES NO

Please list here:

Sign by Patient: …………………………………………

If it is signed by someone else, your relationship to patient: ……..............................................

Date: …………………………………………………………

Cheeked / Review by Member of staff:

Name:

Date