

**Patient Screening Form**

**Name:**

**Date:**

|  |  |  |
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|  | **Pre-Appointment** | **In Office** |
| Any fever recently (last 14-21 days)? | **□** Yes **□** No | **□** Yes **□** No |
| Any SOB (shortness of breath)? | **□** Yes **□** No | **□** Yes **□** No |
| Any cough? | **□** Yes **□** No | **□** Yes **□** No |
| Any flu-like symptoms, GI upset, HA, fatigue? | **□** Yes **□** No | **□** Yes **□** No |
| Any loss of taste or smell? | **□** Yes **□** No | **□** Yes **□** No |
| Any contact with known COVID + patients? | **□** Yes **□** No | **□** Yes **□** No |
| Over 60 years old? | **□** Yes **□** No | **□** Yes **□** No |
| Any known DM/heart/lung/kidney disease? | **□** Yes **□** No | **□** Yes **□** No |
| Any auto-immune disorders? | **□** Yes **□** No | **□** Yes **□** No |
| Any foreign travel in past 14 days? | **□** Yes **□** No | **□** Yes **□** No |

Any positive responses require physician discussion prior to elective treatments.