COVID-19 SCREENING QUESTIONNAIRE

In response to the recent Coronavirus (COVID-19) outbreak and the raised pandemic alert status by the World Health Organization (WHO), Rathna Nuti MD is taking precautions to lessen the spread of the virus. All patients must have a screening form completed prior to the visit.

Please review the following criteria:

	Yes	No
Have you or anyone in the household tested positive for COVID-19?		
Have you or anyone in the household been tested for COVID-19 and are awaiting results?		
Do you or anyone in the household have any of the following respiratory symptoms: fever, sore throat, cough, shortness of breath?		
Have you or anyone in the household recently lost your sense of smell or taste?		
Do you or anyone in the household have any GI symptoms? Diarrhea? Nausea?		
Even if you don't currently have any of the above symptoms, have you or anyone in the household experienced any of those symptoms in the last 14 days?		
Have you or anyone in the household been in contact with someone who has tested positive for COVID-19 in the last 14 days?		
Have you or anyone in the household traveled outside of the United States by air or cruise ship in the past 14 days?		
Have you or anyone in the household traveled within the United States by air, bus, or train within the past 14 days?		

By signing below, you certify that the answers above are true, you do not meet the criteria above, and that you have been provided with this information.

I HAVE REVIEWED THE ABOVE CRITERIA AND I DO NOT HAVE SYMPTOMS AS DESCRIBED.

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Patient/ Guardian/ Representative Printed Name

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Relationship to patient (if signed by other than patient) **Witness (optional)**

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Patient/ Guardian/ Representative Signature **Date**

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