COVID19 screening form.

Patient Full Name * _____ **Date of birth** * _____
First Name Last Name MM/DD/YYYY

Phone Number * _____

Do you or your child have any of the following symptoms?: * **CHECK ALL THAT APPLY**

- New and persistent cough
- Shortness of breath or any difficulty breathing
- Fever
- No Symptoms

Have you or your child been in contact with anyone in the last 14 days who is experiencing these symptoms? * **CHECK ONE**

- Yes
- No

Have you or your child been in contact with anyone who has since tested positive for Covid-19? * **CHECK ONE**

- Yes
- No
- Not Sure

Have you or your child traveled abroad in the last 1-2 months? _____

Where did you go?_____

Reason for appointment: *

_____

_____

Person filling out this form : * _____**Date:** * _____