COVID-19 Symptom Assessment/Pre-screening

New or worsening cough?	___Yes ___No
Sudden Loss of Taste or Smell?	___Yes ___No
Fever or feeling feverish?	___Yes ___No
Sudden onset of fatigue?	___Yes ___No
Shortness of breath?	___Yes ___No
Muscle Pain?	___Yes ___No
Sore throat?	___Yes ___No
Body and/or muscle aches?	___Yes ___No
Nausea/vomiting/diarrhea?	___Yes ___No
Known exposure to someone with COVID-19 in past 14 days?	___Yes ___No
Have you tested positive for COVID-19 in the past 30 days?	___Yes ___No
Recent Travel (past 14 days)?	___Yes ___No

Signature_____ Date_____

Do Not write below this line

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Temperature _____ Covid Consent signed_____

Clinician Signature_____