Coronavirus COVID-19: Patient Risk Questionnaire

Please note that this questionnaire should be completed each time the patient arrives at the office

Date: _____

Verbal Screening:

1. Have you traveled outside of the U.S. in the past 30 days? Yes No
2. Have you traveled domestically within the U.S. in the past 30 days? Yes No
3. Have you been in direct contact with a COVID-19 patient or an individual with COVID-19 like symptoms? Yes No
4. Are you experiencing any of the following flu-like symptoms?
    a. Shortness of breath Yes No
    b. Fever Yes No
    c. Cough Yes No

Visual Screening:

Please complete visual assessment based on patient's physical appearance:

- Coughing Yes No
- Sneezing/runny nose Yes No
- Pale skin Yes No
- Fatigued Yes No
- Sweating Yes No
- Shaking Yes No

Patient Name: _____ DOB: _____

Patient Signature: _____

Internal Office Use

Name of Person Reviewing Results: _____

Can the person be treated at the office today? Yes No

Last edited: 3/2120