



Patient Arrival COVID-19 Questionnaire

Patient Name: _____

DATE: _____

DATE: _____

DATE: _____

Patient Temp: _____

Patient Temp: _____

Patient Temp: _____

	Yes	No	Yes	No	Yes	No
1. Do you have a fever (>100.0), cough, sore throat, shortness of breath?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Any loss of taste, smell or appetite?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Vomiting, nausea, diarrhea?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Headaches, body aches?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you had conjunctivitis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Any chills/repeated shaking with chills?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you been experiencing extreme fatigue?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you had any blue discoloration/blisters on toes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you been in known contact with someone who has had these symptoms?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Patient Signature: _____

Date: _____

Patient Signature: _____

Date: _____

Patient Signature: _____

Date: _____

OFFICE USE ONLY

PT Initials: _____ Date: _____

PT Initials: _____ Date: _____

PT Initials: _____ Date: _____