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|  | **PRE-APPOINTMENT** | **IN-OFFICE** |
|  | Date: | Date: |
| Do you have fever or have you felt hot or feverish recently (14-21 days)? | Yes | No | Yes | No |
| Are you having shortness of breath or other difficulties breathing?  | Yes | No | Yes | No |
| Do you have a cough? | Yes | No | Yes | No |
| Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue? | Yes | No | Yes | No |
| Have you experienced recent loss of taste or smell? | Yes | No | Yes | No |
| Have you been in contact with any confirmed COVID-19 positive patients? If Yes: WHEN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (if <2 weeks postpone), Were you tested? Y / N; Type of Covid Test Swab / Antibody; Results of Covid Test + / - | Yes | No | Yes | No |
| Are you over the age over 60? | Yes | No | Yes | No |
| Do you have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders? IF YES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Yes | No | Yes | No |
| Have you traveled out of Santa Clara County in the past 14 days? If YES: Where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Yes | No | Yes | No |

**Patient Screening Form**