



Scott Froum DDS, PC

COVID-19 Screening Form ...

Patient's name:

Date:

Date:

PREAPPOINTMENT CHECK

IN-OFFICE VISIT

1. Have you previously been diagnosed with COVID-19, or do you think you've had/have COVID-19?

YES NO

YES NO

(If NO to question 1, skip to question 5)

2. If YES, when and how were you confirmed positive?

- I think I had it.
- I had a positive nasal swab test.
- I had a positive blood test.
- I had a positive saliva test.
- I currently have symptoms and am waiting for a test.

3. If you have had COVID-19, how were you confirmed negative?

- I was diagnosed negative by a nasal swab test. How many times? How far apart?
- I show antibodies to COVID-19 with a blood test.
- My doctor said I no longer have it because I don't have any symptoms.
- I don't have any symptoms, so I don't have it.

4. If you have had COVID-19, when were you confirmed negative?

- 24 hours ago today 10 days after testing

5. Do you currently have (or have you experienced) any of the following symptoms in the past 21 days:

- | | | |
|--|--|--|
| Fever | YES <input type="checkbox"/> NO <input type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| | <i>If fever, how did you measure it?</i> | |
| Fatigue (feeling tired) | YES <input type="checkbox"/> NO <input type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| Altered or loss of taste/smell | YES <input type="checkbox"/> NO <input type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| Dry cough | YES <input type="checkbox"/> NO <input type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| Trouble breathing | YES <input type="checkbox"/> NO <input type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| Shortness of breath, difficulty breathing, chest tightness | YES <input type="checkbox"/> NO <input type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| Confusion | YES <input type="checkbox"/> NO <input type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| Blueish lips or face | YES <input type="checkbox"/> NO <input type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| Chills/repeated shaking with chills | YES <input type="checkbox"/> NO <input type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| Muscle pain | YES <input type="checkbox"/> NO <input type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| Headache or sore throat | YES <input type="checkbox"/> NO <input type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> |

Any other flu-like symptoms YES NO PLEASE LIST

YES NO PLEASE LIST

GI upset or diarrhea YES NO

YES NO

6. Are you in contact with anyone who has been sick and/or confirmed to be COVID-19–positive?

YES NO

YES NO

7. In the past 14 days have you traveled to any regions affected by COVID-19?

YES NO

YES NO

Some medical conditions have been associated with more severe COVID-19 disease. The following questions are an attempt to determine your risk:

8. Are you over age 65? YES NO

YES NO

9. Do you have high blood pressure? YES NO

YES NO

If you have high blood pressure, is it controlled?

YES NO

YES NO

10. Do you have diabetes? YES NO

YES NO

11. Are you overweight? YES NO NO ANSWER

YES NO NO ANSWER

12. Do you have respiratory problems? YES NO

YES NO

13. Do you have any autoimmune disorders?

YES NO

YES NO

14. Are there any other conditions you would like to report?