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 ☐ NO ☐	YES ☐ NO ☐
	If fever, how did you measure it?	
Fatigue (feeling tired)	YES ☐ NO ☐	YES ☐ NO ☐
Altered or loss of taste/smell	YES ☐ NO ☐	YES ☐ NO ☐
Dry cough	YES ☐ NO ☐	YES ☐ NO ☐
Trouble breathing	YES ☐ NO ☐	YES ☐ NO ☐
Shortness of breath, difficulty breathing, chest tightness	YES ☐ NO ☐	YES ☐ NO ☐
Confusion	YES ☐ NO ☐	YES ☐ NO ☐
Blueish lips or face	YES ☐ NO ☐	YES ☐ NO ☐
Chills/repeated shaking with chills	YES ☐ NO ☐	YES ☐ NO ☐
Muscle pain	YES ☐ NO ☐	YES ☐ NO ☐
Headache or sore throat	YES ☐ NO ☐	YES ☐ NO ☐

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?