360 INFUSION CENTER

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COVID-19 PATIENT SCREENING QUESTIONNAIRE

*Indicate Yes or No and provide relevant comments.

Patient Name: ______________________________ **Date:** ______________

Screening Questions	Pre-Appointment*	In-Office*	Post-Appointment* follows up with the patient 2 days post-appointment to ask if they have developed symptoms or have been diagnosed with COVID-19.
Do you have a fever, or have you felt feverish recently?			
Do you have a cough?			
Are you having shortness of breath or any difficulty breathing?			
Do you have chills or repeated shaking with chills?			
Do you have any muscle pain or body aches?			
Do you have any recent onset of headache or sore throat?			
Have you been experiencing nausea and/or vomiting?			
Do you have any recent loss of taste or smell?			
Have you been experiencing fatigue recently?			
Have you experienced any recent GI upset or diarrhea?			
Have you been advised to self-quarantine because of exposure to someone with COVID-19?			
Have you traveled in the past 14 days to any regions affected by COVID-19?			
Have you been tested for COVID-19? If yes, what was the result?			
Have you been diagnosed with COVID-19? If yes, when?			
Are you over the age of 65? Do you have: Heart disease Lung disease Kidney disease Diabetes Autoimmune disorders			