Patient Screening Form

Patient Name: ___________________________________

Date: ____________

Questions	YES	NO
Have you traveled outside the country: China, Italy, Iran, South Korea, anywhere in Europe in the past 14 days		
Cough		
Fever		
Shortness of Breath		
Chest Pain		
Have you been in contact with anyone who has tested positive for or suspected of COVID-19 in the past 30 days		

Patient Signature:____