

Pre-Appointment Covid-19 Screening

Screening questions	
	NO YES
Have you been vaccinated for COVID 19?	
Have you lost sense of smell or taste?	
In the last 5 days have you experienced any of the following? - runny nose - sore throat - headache - unexplained muscle pain - dry cough - chills or shaking with chills - fever or above (>100.4° F)?	
What was the result of your COVID-19 test, if done?	NEG POS

Patient's Name

Signature