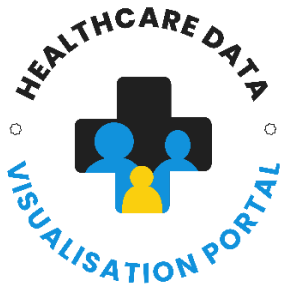

COVID-19 Screening Form

Patient Name: _____
Date of Birth: _____
Address: _____
Phone Number: _____
Email: _____

Please answer the following questions:

1. Have you experienced any of the following symptoms in the past 14 days? (Check all that apply)
   - [ ] Fever or chills
   - [ ] Cough
   - [ ] Shortness of breath or difficulty breathing
   - [ ] Fatigue
   - [ ] Muscle or body aches
   - [ ] Headache
   - [ ] Sore throat
   - [ ] New loss of taste or smell
   - [ ] Congestion or runny nose
   - [ ] Nausea or vomiting
   - [ ] Diarrhea

2. Have you tested positive for COVID-19 in the last 14 days?
   - [ ] Yes
   - [ ] No
   - [ ] Not Sure

3. Have you traveled internationally or domestically in the last 14 days?
   - [ ] Yes
   - [ ] No

4. Have you had close contact with a confirmed or suspected COVID-19 case?
   - [ ] Yes
   - [ ] No

5. Are you currently under quarantine or advised to self-isolate?
   - [ ] Yes
   - [ ] No

6. Are you awaiting COVID-19 test results?
   - [ ] Yes

- [ ] No

7. Additional Comments:

_____

I confirm that the information provided above is accurate to the best of my knowledge.

Patient/Guardian Signature: _____
Date: _____

Witness Signature (if required): _____
Date: _____