PATIENT PRE-SCREENING QUESTIONNAIRE

Due to the ongoing COVID-2019 Pandemic, all patients are required to complete this form before being seen. Thank you for your cooperation

NAME:_____ DATE:_____ TEMP:_____

	Yes	No
Have you, your caregiver (if applicable) or anyone in your household **travelled outside the US** in the **past 2 weeks (14 days)** **IF YES, WHERE: _____**		
Have you or your caregiver (if applicable) or anyone in your household t**ravelled outside of DC, Maryland or Virginia** in the **past 2 weeks (14 days) IF YES, WHERE** _____		
In the past **2 weeks (14 days)** has the patient, caregiver or anyone in your household had contact with **any person suspected** to have contracted coronavirus (COVID-19)? **Including being tested for COVID-19 and/or being in self isolation for COVID-19**		
In the **past 2 weeks (14 days)** has the patient, caregiver or anyone in your household had contact with any person **confirmed to have contracted COVID-19?**		
Has the patient or caregiver(if applicable) currently been exposed to someone with **flu-like symptoms (cough, shortness of breath or fever)**		
IN THE LAST 72 HOURS HAS THE PATIENT OR CAREGIVER EXPERIENCED		
FEVER		
COUGHING		
SORE THROAT		
DIFFICULTY BREATHING, SHORTNESS OF BREATH OR WHEEZING		
STOMACH PAINS		
VOMITING OR DIARRHEA		
PINK EYE/ RED EYES		
RASH		
FATIGUE OR FEELING UNWELL		

By signing below, you certify that the answers above are true. Failure to answer truthfully or withholding information intentionally will lead to immediate dismissal from our practice and may be subject to applicable legal actions and fines.

Patient/Caregiver:_____ Printname_____

Date:_____

Caregiver temp(if applicable):_____