COVID-19 Screening Questionnaire

Patient Name: ________________________________ Date: ______________________

	Please circle one:	
Have you knowingly been in close or proximate contact in the past 14 days with anyone who has tested positive for COVID-19 or who has had symptoms of COVID-19?	**YES**	**NO**
Have you tested positive for COVID-19 in the past 14 days?	**YES**	**NO**
Have you experienced any symptoms of COVID-19 in the past 14 days? • Fever (>100.0 °F) or chills • Cough • Shortness of breath or Difficulty breathing • Fatigue • Muscle or body aches • Headache • New loss of taste or smell • Sore throat • Sudden/Active diarrhea	**YES**	**NO**
In the past 14 days, have you traveled **more than 24 hours** to a state or country for which New York State requires a quarantine?	**YES**	**NO**
If yes, have you quarantined for at least 3 days, been tested for COVID-19 on or after the 4th day of returning to New York and received a negative test result? Or have you quarantined for 14 days?	**YES**	**NO**
In the past 14 days, have you traveled **less than 24 hours** to a state or country for which New York State deems to have significant community-wide spread of COVID-19?	**YES**	**NO**
If yes, did you take a COVID test on or after the 4th day following your arrival and receive a negative test result?	**YES**	**NO**
Do you have any current symptoms of illness?	**YES**	**NO**