COVID-19 SCREENING QUESTIONNAIRE

In response to the Coronavirus (COVID-19) outbreak, Inland Urgent Care is taking precautions to lessen the spread of the virus. All patients must have a screening form completed.

Please review the following self-screening criteria: *	Yes	No
Has the patient or anyone in the family (household) tested positive for COVID-19? When:_____	☐	☐
Has the patient or anyone in the family (household) been tested for COVID-19 and are awaiting results?	☐	☐
Does the patient or anyone in the family (household) have any of the following symptoms? Fever greater than 100.4°, Chills, Body Aches, Sore Throat, Cough, Shortness of Breath?	☐	☐
Has the patient or anyone in the family (household) recently lost your sense of smell or taste?	☐	☐
Does the patient or anyone in the family (household) have any GI symptoms? Diarrhea? Nausea?	☐	☐
Even if you don’t currently have any of the above symptoms, has the patient or anyone in the family (household) experienced any of these symptoms in the last 14 days?	☐	☐
Has the patient or anyone in the family (household) been in contact with someone who has tested positive for COVID-19 in the last 14 days?	☐	☐

- ***If a patient is found to be untruthful, in any of the above answers regarding their exposure or risk they will be dismissed from the practice upon discovery.***

Please sign below indicating that you have been provided with this information.

I HAVE REVIEWED THE ABOVE CRITERIA AND HAVE ANSWERED HONESTLY TO THE BEST OF MY KNOWLEDGE.

Patient Name: ______________________ Patient Signature: _________________ Date________