Patient's Name: _____ **Date of Birth:** _____

Address: _____ **Zip Code** _____

Birth Sex: **Male** **Female** **Phone(** **)** _____

Email: _____ **Race/Ethnicity** _____

COVID-19 Screening

Frontline Worker Occupation: _____

Role: ○ Public Servant ○ Non-public Servant ○ Frontline Worker

1. Do you have any new fevers, cough, shortness of breath, loss of smell/taste, aches, fatigue, or sore throat in the past 7 days? ○ No ○ Yes

Check all that apply:

☐ Fever	☐ Loss of taste	☐ Chills
☐ Cough	☐ Aches	☐ Diarrhea
☐ Shortness of breath	☐ Fatigue	☐ Headache
☐ Loss of smell	☐ Sore throat	☐ Chest Pain

2. Have you been in close contact (sharing household items or within 6 feet) with a known case of COVID-19 without protective equipment? ○ No ○ Yes

3. Are you currently quarantined from work? ○ No ○ Yes

Date of exposure: / /

Start date of quarantine: / /

4. Underlying Health Conditions:

a. Immuno-compromised (e.g. receiving chemotherapy, transplant, HIV)?	○ No	○ Yes	○ Unknown
b. Aging adult >60?	○ No	○ Yes	○ Unknown
c. Congestive Heart Failure or Congenital Heart Disease?	○ No	○ Yes	○ Unknown
d. Diabetes?	○ No	○ Yes	○ Unknown
e. End Stage Renal Disease?	○ No	○ Yes	○ Unknown
f. Chronic Pulmonary Disease (e.g. COPD, Asthma, ILD)?	○ No	○ Yes	○ Unknown
g Pregnant Woman?	○ No	○ Yes	○ Unknown

Do you give consent to be tested for COVID-19? ☐**YES** ☐**NO**

Do you give consent for your results to be emailed electronically to you? ☐**YES** ☐**NO**

_____ _____

Patient's Signature **Date**