Dr. Anne Starr & Associates

COVID-19 Screening Questionnaire

Patient name:_____

Do you have a fever or have you felt hot or feverish anytime in the last two week?	☐ **Yes** ☐ **No**
Do you have any of these symptoms, Dry cough? Shortness of breath? Difficulty breathing? Sore throat? Runny nose? Post nasal drip?	☐ **Yes** ☐ **No**
Do you have any flu like symptoms such as gastrointestinal upset, headache or fatigue?	☐ **Yes** ☐ **No**
Have you experienced recent loss of taste or smell?	☐ **Yes** ☐ **No**
Have you been in contact with anyone confirmed COVID-19 positive patients, or persons self isolating because of a determined risk for COVID-19?	☐ **Yes** ☐ **No**
Is your age over 60?	☐ **Yes** ☐ **No**
Do you have heart disease, lung disease, kidney disease, diabetes or auto-immune disorder?	☐ **Yes** ☐ **No**
Have you travelled outside the area in the past 14 days or have been in contact with anyone outside the area that is experiencing any flu like symptoms?	☐ **Yes** ☐ **No**
Temperature check	☐ **Yes**

If you answer "yes" to any of the above questions, please speak to a member of our clinical staff prior to your appointment and consider delaying elective treatment.

Patient/Guardian Signature_____Date:_____

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