MBP COVID SCREEN QUESTIONNAIRE

DATE:____

NAME:____

DOB:____

1. Within the last 10 days has the patient been diagnosed with COVID-19 or had a test confirming you have the virus? YES NO

2. Does the patient live in the same household with, or have you had close contact with someone who in the past 14 days has been in isolation for COVID-19 or had a test confirming they have the virus? YES NO

3. Has the patient or anyone in the household had any one or more of these symptoms today or within the past 24 hours, which is new or not explained by another reason? YES NO

- Fever, Chills, or Repeated Shaking/Shivering
- Cough
- Sore Throat
- Shortness of Breath, Difficulty Breathing
- Feeling Unusually Weak or Fatigued
- Loss of Taste or Smell
- Muscle pain
- Headache
- Runny or congested nose
- Diarrhea

If the answer to any question is "yes", call our office to reschedule your appointment. If all "no", bring this form with you to your appointment.

SIGNATURE:____

(SELF IF 18+, PARENT OR GUARDIAN)