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COVID-19 Patient Screening Questionnaire & Acknowledgement- Capital City Gastroenterology

COVID-19 Patient Screening Questionnaire

All questions marked with an asterisk (*) are required and must be completed before you are able to submit the survey.

Patient Name *

Date of Birth *

Are you currently experiencing, or have experienced in the past 14 days, any of the following symptoms?

Fever or feeling feverish?*
- Yes
- No

Cough*
- Yes
- No

Shortness of Breath or difficulty breathing*
- Yes
- No

Sore Throat *
- Yes
- No

New loss of taste or smell*
- Yes
- No

Chills*
- Yes
- No

Head or muscle aches*
- Yes
- No

Nausea, diarrhea, vomiting*
- Yes
- No

In the past 14 days, have you been in close proximity to anyone who was experiencing any of the above symptoms?*
- Yes
- No

In the past 14 days, have you been in close proximity to anyone who has tested positive for COVID-19?*
- Yes
- No

Have you been tested for COVID-19*
- Yes

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If yes, what was the result?

List the date of test

In the past 14 days, have you been on a commercial flight or traveled outside the United States*

- Yes
- No

COVID-19 is a highly contagious disease that can lead to severe illness and death. According to the Centers for Disease Control and Prevention, senior citizens and individuals with underlying medical conditions are especially vulnerable. (For a list of underlying medical conditions, see https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-at-higher-risk.html). We are following safety recommendations to help prevent the spread of COVID-19, and we ask that our patients also follow safety precautions (such as social distancing and wearing facemasks when possible).However, there is still an inherent risk of exposure to COVID-19 even when following the recommended guidelines. By signing this form, you acknowledge and understand there is a possibility of contracting COVID-19, and you agree to continue with this office visit.

Patient Signature/ Guardian *

Clear

COVID-19 Patient Screening Questionnaire & Acknowledgement- Capital City Gastroenterology will be submitted to **Capital City Gastroenterology**

Submit

*You have **15** required fields to fill out. Click here to show them.*