2019 Novel Coronavirus Screening 2020 Questionnaire

Patient/Visitor Name: _____ DOB:_____

Please circle YES or NO to the following questions:

1.) Have **you and/or anyone accompanying you today** traveled outside the U.S.A in the last 14 days?

YES NO

2.) Have **you and/or anyone accompanying you today** been in close contact with a person known to have 2019 Novel Coronavirus?

YES NO

3.) Do you **and/or anyone accompanying you today** currently have a fever or any respiratory symptoms such as a cough or shortness of breath?

YES NO

If answered yes to any of the above:

Name of person: _____ Phone #: _____

Dates of Travel & Location: _____

Signature of person completing this questionnaire: _____

Relationship to patient/minor (if applicable): _____ Date:_____

Nurse Assessment: _____

Temp: _____ Additional Vitals (if needed): _____

Additional Assessment needed? Yes / No

_____

Nurse: _____ Date/Time: _____