Embrace Wellness

COVID-19 Symptom/Exposure Screening Questionnaire

PATIENT & DOB: | Date:

Phone Screening:

Do you have now, or have you had any of the following symptoms in the past 14 days?

☐ Fever or chills

☐ Dry cough, shortness of breath or difficulty breathing

☐ Fatigue

☐ Body aches

☐ Headache

☐ New loss of taste or smell

☐ Nausea, vomiting or diarrhea

Have you had lab diagnosed COVID? YES ☐ NO ☐

- If yes when: _____

Have you had COVID vaccine? YES ☐ NO ☐

- Dose 1 ☐ Dose 2 ☐

Have you been or potentially been exposed to anyone with the above symptoms or a recent positive COVID-19 test? ☐ **Yes** ☐ **No**

☐ **Reminder – Mask Required** ☐ **Reminder – No Guests, Pt only in Clinic**

In-Office Use Only

Day of visit recorded temp: _____

Staff Initials: _____ Date: _____ Time: _____

☐ Left Message to call for Pre-Screen ☐ Screening Completed Staff Initials: _____