COVID-19 Screening Questionnaire

Question	No	Yes	If YES
1. Have you or has anyone in your house been tested for COVID-19 coronavirus in the past 14 days?	❒ No	❒ Yes	If YES, 1. What the date of your test? ____________________ 2. What were the results? _______________________
2. Have you or has anyone in your house had contact with someone who was diagnosed with COVID-19 coronavirus in the past 14 days?	❒ No	❒ Yes	If YES, What was the date of exposure to that person? ____
3. Have you or has anyone in your home had fever, felt hot or feverish in the last two days?	❒ No	❒ Yes	If YES, 1. Were you able to measure the temperature with a thermometer? ❒ Yes ❒ No 2. If YES, what was the temperature? ______________ 3. When was the date it was measured? ____________
4. Are you or is anyone in your home experiencing shaking, chills, sweating or feel very warm to the touch?	❒ No	❒ Yes	If YES, 1. When did symptoms begin? ___________________ 2. Was fever-reducing medication given? ___________
5. Have you or has anyone in your home recently been experiencing shortness of breath?	❒ No	❒ Yes	
6. Do you or does anyone in your home have a cough?	❒ No	❒ Yes	If YES, 1. Have you or this person been coughing up any blood? ❒ Yes ❒ No 2. If YES, how much blood? _______________
7. Have you or has anyone in your home been on a cruise within the last 14 days?	❒ No	❒ Yes	

UCA TEAM MEMBERS: If all responses are **NO**, the patient may be scheduled for an appointment.

For any **YES** response(s), please forward appropriately to the following:

- Phone Triage Nurse if appointment is being scheduled via telephone or patient portal
- Physician's Nurse if patient is in-house for further evaluation and follow-up with physician

____ ______________________

Patient Name (Printed) Date of Birth

____ ______________________

Patient/Visitor Signature Date

____ ______________________

UCA Team Member Signature Date

Revised 4/8/2020