BAY WEST ENDOCRINOLOGY ASSOCIATES

COVID-19 Illness Screening Form

Date: _____

Patient: _____ DOB: _____

Provider: _____

1. **<u>Within the last two weeks</u>, have you experienced any of the following symptoms**?
   a. Difficulty Breathing YES___ NO___
   b. Cough YES___ NO___
   c. Fever YES___ NO___ *Today:_____ (<=99.0)
   d. Loss of taste or smell YES___ NO___

2. ***Have you been tested for COVID in the past 30days (and the results are pending or positive)?**

   Yes_____ No_____

   If YES, when?_____

3. ***Have you been in close contact (within 6 feet for >3 minutes) in the last 14 days of someone who is COVID+?**

   Yes_____ No_____

4. ***Have you received the Covid-19 vaccine?**

   Yes_____ No_____

   If YES, has it been two weeks since you've received your second dose?

   Yes_____ No_____

IF YES is answered, to two or more of question 1, the provider will be notified.

***If your temperature is over 99.0 or you answer yes to question 2 or 3, you will be asked to reschedule your appointment.**

Patient Signature:_____