BAY WEST ENDOCRINOLOGY ASSOCIATES

COVID-19 Illness Screening Form

Date: _____

Patient: _____ DOB: _____

Physician: _____

Temperature _____

1. **Within the last two weeks, have you experienced any symptoms of Covid-19, such as difficulty breathing, cough, fever, loss of taste or smell?** Yes_____ No_____

*****If YES to question #1, notify the provider, if NO, continue with questions 2 and 3*****

2. **Have you received your covid-19 vaccine?** Yes_____ No_____

3. **Have you been tested for COVID or been in close contact (within 3ft. for >3min.) in the last 14days?** Yes_____ No_____