# COVID-19 PRE-SCREENING PATIENT QUESTIONNAIRE FORM

Please call us before attending the clinic for a pre-booked appointment if you answered yes to any of the following questions (please complete no more than 24 hours prior to your appointment)

| COVID SCREENING FORM | YES | NO |
|---|---|---|
| Have you tested positive for COVID-19 in the last 7 weeks? | | |
| If yes, please specify: | | |
| Within the last 2 weeks, have you experienced high temperature or fever above 37.8°C? | | |
| If yes, please specify: | | |
| Within the last 2 weeks, have you recently experienced a new shortness of breath that you cannot attribute to another health condition? | | |
| If yes, please specify: | | |
| Within the last 2 weeks, have you recently experienced a sore throat, loss of taste or smell that you cannot attribute to another health condition? | | |
| If yes, please specify: | | |
| Within the last 2 weeks, have you or a member of your household been isolating? | | |
| If yes, please specify: | | |

If you answer yes to any of these questions, please reschedule your appointment.

**Patient signture:** **Date:**