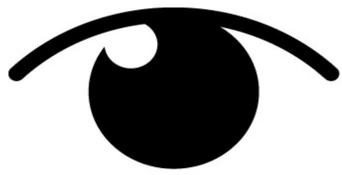

OPHTHALMIC CONSULTANTS of the Capital Region

COVID-19 PATIENT SCREENING QUESTIONNAIRE

*Indicate Yes or No by marking an "X" in the boxes.

Patient Name: ______________________________ Date: ____________________

If you have had any symptoms noted below but controlled them with medications (ex: aspirin), please indicate "yes" to the question. **Screening Questions**	**YES**	**NO**	**Comments**
Do you have a new, current, or recent (within the past 3 days) **fever?**			
Do you have a new, current, or recent (within the past 3 days) **cough?**			
Do you have a **chronic cough?**			
Do you have a new, current, or recent (within the past 3 days) **headache?**			
Are you having shortness of breath or any difficulty **breathing?**			
Do you have chills or repeated shaking with **chills?**			
Do you have any **muscle pain?**			
Do you have any other **flu-like symptoms?**			
Do you have now, or have you had a recent (within the past 3 days) onset of a **sore throat?**			
Do you have now or any recent (within the past 3 days) **loss of taste or smell?**			
Have you experienced any recent (within the past 3 days) **GI upset or diarrhea?**			
Are you in contact with anyone who has been confirmed to be COVID-19 positive?			
Have you traveled in the past 14 days to any regions affected by COVID-19?			
Have you been tested for COVID-19 or waiting for COVID-19 test results? If yes, what was the result?			
Were you tested for Covid-19 because you had related symptoms? If no, please explain.			
Have you ever been diagnosed with COVID-19? If yes, when?			

I am aware of and will adhere to the mask and cell phone and other handheld devices policy that Ophthalmic Consultants of the Capital Region has posted. I am also aware that if I do not adhere to these policies, I will be asked to reschedule my appointment. ______
initials

Patient Signature ______________________________ Date______________________________