DR GAVIN M DAVISON
orchard park aesthetics

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the art of beauty and medicine

COVID-19 SCREENING QUESTIONNAIRE

Patient Name:_____ DOB:_____

In the past 14 days, have you or any household member had any of the following?

Yes ☐ No ☐ Fever (100˚F or greater as measured by a thermometer)

Yes ☐ No ☐ Cough

Yes ☐ No ☐ Shortness of breath or difficulty breathing

Yes ☐ No ☐ Sore throat

Yes ☐ No ☐ New loss of taste or smell

Yes ☐ No ☐ Chills

Yes ☐ No ☐ Headache or muscle aches

Yes ☐ No ☐ Nausea, diarrhea, vomiting

Yes ☐ No ☐ Have you received a positive test result for COVID-19?

Yes ☐ No ☐ A pending screening test for COVID-19?

Yes ☐ No ☐ Have you had close contact with a confirmed or suspected COVID-19 case?

Yes ☐ No ☐ Have you had traveled to/from a designated state with significant community spread?

Yes ☐ No ☐ Is anyone in your home currently under quarantine or isolation?

If you answered "Yes" to any of these, please explain.
For example, if you have chronic respiratory or GI symptoms related to a long-standing medical condition, please clarify in the space below.

Signature: _____ Date:_____

This section to be completed by health screener

Patient Temperature Upon Entering Facility: _____

Health screener signature:_____

Note: The information collected on this form will be only used to determine whether you may be infected with COVID-19. The information on this formed is maintained as confidential.