Complete
CARDIAC AND VASCULAR CARE

Viral Lathia, MD

COVID-19 Active Screening Questionnaire

Name: _____ DOB: _____ Medical Record #: _____

1. Within the last 14 days, have you experienced any **cough** that you cannot attribute to another health condition? ◯ Yes ◯ No

2. Within the last 14 days, have you experienced any **shortness of breath** that you cannot attribute to another health condition? ◯ Yes ◯ No

3. Within the last 14 days, have you experienced any **sore throat** that you cannot attribute to another health condition? ◯ Yes ◯ No

4. Within the last 14 days, have you experienced any **muscle aches** that you cannot attribute to another health condition? ◯ Yes ◯ No

5. Within the last 14 days, have you had a temperature at or **above 100.4°F** or the sense of having a fever? ◯ Yes ◯ No

6. Within the last 14 days, have you had **close contact**, without the use of appropriate PPE, with someone who is currently sick with suspected or confirmed COVID-19?
   (Note: Close contact is defined as within 6 feet for more than 10 consecutive minutes)
   ◯ Yes ◯ No

PLEASE BE SURE TO WEAR YOUR MASK PROPERLY AT ALL TIMES

X _____ _____

Patient/Guardian Signature Date