Spectrum DERMATOLOGY

COVID QUESTIONNAIRE

1. Do you have a fever?

☐ Yes ☐ No

2. Do you have any of the following signs or symptoms?

☐ New onset of cough ☐ Worsening chronic cough ☐ Sore throat ☐ Shortness of breath

☐ Difficulty breathing ☐ New loss or decrease in sense of taste or smell ☐ Runny nose ☐ Chills

☐ Headache ☐ Unexplained fatigue or malaise ☐ Difficulty swallowing

☐ Nausea/vomiting, diarrhea, abdominal pain ☐ No symptoms

3. Have you travelled or have had close contact with anyone who has travelled in the past 14 days?

☐ Yes ☐ No

4. Have you had close contact with anyone with respiratory illness or a confirmed or probable/suspected case of COVID-19?

☐ Yes (if yes, go to question 5) ☐ No (if no, screening is complete)

5. Did you wear the required and/or recommended PPE according to the type of duties you were performing (e.g., goggles, gloves, mask and gown or N95 with aerosol generating medical procedures) when you had close contact with a suspected or confirmed case of COVID-19?

☐ Yes ☐ No

If you have answered "yes" to questions 1, 3, or have checked off signs or symptoms, you may need to reschedule your appointment.

If you have answered "yes" to question 4 but "yes" to question 5, you may proceed with your appointment.

_____

Patient Name

_____ _____

Patient or Guardian Signature Date

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