**PATIENT PRE-SCREENING QUESTIONNAIRE**

**Due to the ongoing COVID-19 Pandemic, all caregivers/patients are required to complete this form prior to being seen at Prima Health Clinic. Your visit is subject to approval upon completion of this form. Effective immediately, only 1 caregiver is to accompany our patient visits, accompanying children who are not being seen as patients are also restricted. These rules are being enforced to keep our patients and staff as well as the rest of your loved ones safe and healthy.**

|  |  |  |
| --- | --- | --- |
|  | **YES** | **NO** |
| Has the patient, caregiver or anyone in your household have travelled **outside the US in the past 2 weeks (14 days)****IF YES, WHERE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |  |  |
| Has the patient, caregiver or anyone in your household have travelled **outside of Texas in the past 2 weeks (14 days)****IF YES, WHERE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |  |  |
| In the past 2 weeks (14 days) has the patient, caregiver or anyone in your household had contact with any person **suspected to have contracted coronavirus (COVID-19)?**Including being ***tested*** for COVID-19, & being in ***self isolation*** for COVID-19 |  |  |
| In the past 2 weeks (14 days) has the patient, caregiver or anyone in your household had contact with any person **confirmed to have contracted coronavirus (COVID-19)**? |  |  |
| Has the patient or caregiver currently been exposed to someone **with flu-like symptoms (cough, shortness of breath or fever)?** |  |  |
| **PLEASE CHECK YES OR NO IF SYMPTOMS ARE CURRENTLY BEING EXPERIENCED BY CAREGIVER, PATIENT OR BOTH***IN THE LAST 72 HOURS HAS THE PATIENT OR CAREGIVER EXPERIENCED* |  |  |
| FEVER |  |  |
| CHILLS |  |  |
| COUGHING |  |  |
| CONGESTION OR RUNNY NOSE |  |  |
| DIARRHEA |  |  |
| FATIGUE |  |  |
| HEADACHE |  |  |
| MUSCLE OR BODY ACHES |  |  |
| LOSS OF TASTE OR SMELL |  |  |
| NAUSEA OR VOMITING  |  |  |
| SHORTNESS OF BREATH OR BREATHING DIFFICULTIES |  |  |
| SORE THROAT |  |  |

**\*\*Please return this form to the front desk when completed\*\***

**By signing below, you certify that the answers above are true. Failure to answer truthfully or withholding information intentionally will lead to immediate dismissal from our practice and may be subject to applicable laws during this pandemic.**

**Patient/Caregiver:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Caregiver temp:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient temp:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**