Gary D. Schwartz, MD PC
COVID-19 Screening

Question	Y/ N	Details
Have you or a member of your household had ANY of the following symptoms in the last 21 days? Sore throat, fever, cough, chills, body aches, SOB, loss of smell/taste.		
Have you been tested for COVID-19? What were your test results? If yes, have you had a negative test? Date?		
Have you traveled outside of the state of NJ in the last 3 weeks? Where to?		
Have you traveled outside the US in the last 3 weeks? Where to and when did you return?		
Have you been to an event/ large gathering within the last 3 weeks?		
Do you have any reason to believe you have been exposed to or acquired COVID-19?		
To the best of your knowledge have you been in close proximity to anyone that has tested positive for COVID-19?		

Name:____ **Date:**________________________