1317 Ebenezer Rd Rock Hill, SC 29732

Tel 803-207-8177 Fax 803-207-8130

Screening Questionnaire for COVID-19

Patient Name:
Date:

Please complete the below questions before the start of your treatment:

1. Do you currently have any of the below symptoms?
   a. Fever **Yes / No**
   b. Cough / Sore or Scratchy Throat **Yes / No**
   c. Persistent Headache **Yes / No**
   d. Respiratory infection / Cold Like Symptons **Yes / No**
   e. Shortness of Breath **Yes / No**

2. In the last 14 days, have you had contact with any of the following:
   a. Someone with a confirmed or presumptive diagnosis of COVID-19 **Yes / No**
   b. Someone under investigation for COVID-19 **Yes / No**
   c. Someone with respiratory illness **Yes / No**
   d. Someone who has been asked to quarantine themselves **Yes / No**

3. Have you traveled domestically (USA) or internationally (China, Japan, Italy, Iran, or South Korea) in the last 14 days? **Yes / No**

4. Vaccinated ? CIRCLE All That Apply Moderna 1st 2nd Pfizer 1st 2nd
   Johnson n Johnson 1st Booster 1st 2nd