COVID-19 Screening Survey

(Recommended by Arkansas Department of Health)

Patient Name: _____DOB:_____ Date:_____

Please advise us if you have recently had any of the following:

1. Fever of 100.4 F?
   - o Yes
   - o No
2. Cough, sore throat, shortness of breath, loss of smell/taste or other COVID-19 symptoms?
   - o Yes
   - o No
3. Pneumonia?
   - o Yes
   - o No
4. Have you returned from overseas travel or from states\metropolitan areas considered hot spots for COVID-19 in the last 14 days?
   - o Yes
   - o No
5. Have you had contact with anyone who has Novel Corona virus (COVID-19) within the last 14 days?
   - o Yes
   - o No

Please do not write below this line. Official Use Only.

Temperature:_____ Staff signature:_____