

# South Lake Pediatrics

## Coronavirus /COVID- 19 Patient and Visitor Screening Form

Exposure to COVID-19 is an inherent risk in any public location where people are present; we cannot guarantee you will not be exposed during your visit. We are taking every precaution to protect both you and our staff. This questionnaire is one of those measures so please complete accurately.

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

### Have you, the patient, or anyone in the patients HOUSEHOLD

- 1) Tested positive for COVID-19 in the past **2 weeks**      YES      NO
- 2) Been in close contact with **anyone** who tested positive for COVID-19 in the **past month**.  
YES      NO
- 3) Been in close contact with anyone who is **waiting** on COVID-19 test results.  
YES      NO
- 4) Had any of the following please **check all that apply** (If present, circle if patient or household)
- \_\_\_ FEVER in the last 48 hours ( patient / household )
  - \_\_\_ COUGH ( patient / household )
  - \_\_\_ LOST OF TASTE OR SMELL ( patient / household )
  - \_\_\_ SHORTNESS OF BREATH ( patient / household )
  - \_\_\_ FATIGUE ( patient / household )
  - \_\_\_ MUSCLE ACHES ( patient / household )

- 5) Has the **Patient ever** tested positive for COVID19?      YES      NO  
..during the time of diagnosis did they have any symptoms?      YES      NO

if yes please describe?

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Patient / Parent or Guardian signature: \_\_\_\_\_