ColumbiaDoctors

Name: _____

DOB: _____

Please Review and Check All That Apply and Hand In To Front Desk

COVID 19 Infection Screening

Do you have any of the following:	Yes	No
1) Fever	☐	☐
2) Cough	☐	☐
3) Shortness of Breath	☐	☐

Travel History:

1) Within 14 days of symptom onset, did you travel outside the United States

   Yes ☐ No ☐

2) Have you been in contact with someone who tested positive for COVID-19

   Yes ☐ No ☐

3) If you have been exposed to someone who tested positive for COVID-19, have you self quarantined for 14 days

   Yes ☐ No ☐

Signature:_____

Date: _____