JOE ISAACSON
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PATIENT COVID-19 SCREENING FORM

Patient Name:_____ Age:_____Appt. Date/Time:_____

	PRE-APPOINTMENT
Review Medical Health History: Concerns: _____	☐ Yes ☐ No
Have you had a fever or have you felt hot or feverish recently or in the past 14 days?	☐ Yes ☐ No
Have you had shortness of breath or other difficulties breathing?	☐ Yes ☐ No
Have you had a cough?	☐ Yes ☐ No
Have you had any flu-like symptoms, nausea, headaches, or fatigue?	☐ Yes ☐ No
Have you experienced recent loss of taste or smell?	☐ Yes ☐ No
Have you been in contact with any confirmed COVID-19 positive patients?	☐ Yes ☐ No
Do you have any health concerns that would put you at a higher risk for COVID-19? (Review Concerns from Question 1.)	☐ Yes ☐ No
Have you or anyone you have come in contact with traveled outside of the state or country in the past 14 days? If so, list: _____	☐ Yes ☐ No
Do you currently smoke or vape? (Mark Tobacco Screening on Hygiene Checklist)	☐ Yes ☐ No

Positive responses to any of these questions need to be discussed with Chaz/Dr. Isaacson before confirming their appointment.