Patient Name: Person filling out the form:

Date of Birth: Signature: _____

ATLANTA
PEDIATRIC PARTNERS

COVID-19 Screening Questionnaire

Our families, staff and community mean a great deal to us and your safety is our top priority! During the COVID-19 pandemic, we have instituted a screening process. Please complete this questionnaire prior to entry into our office.

Your responses will be kept confidential and will be reviewed by a practice clinician who will provide guidance regarding any adjustments to the patient's scheduled appointment.

1. Have you or anyone in your house hold had any of the following symptoms in the last 2 days (If yes, please check all the boxes that apply)

- Cough
- Fever at or greater than 100 degrees Fahrenheit
- Chills
- Shortness of breath/difficulty breathing
- Muscle or body aches
- Sore throat
- New loss of taste or smell,
- Diarrhea
- Headache
- Nausea or vomiting
- New fatigue
- Congestion or runny nose

2. Have you or anyone in your household tested POSITIVE for COVID-19?
   YES NO IF YES, WHEN?

3. Have you or anyone in your household cared for an individual who is in quarantine or is a presumptive positive or has tested POSITVE for COVID-19 in the past 21 days?
   YES NO IF YES, WHEN?

4. To the best of your knowledge have you been in CLOSE PHYSICAL CONTACT to any individual who tested positive for COVID-19 in the past 21 days?
   YES NO

For office internal use: 1st clearer: _____