Delmar Internal Medicine /Podiatry **COVID Screening** **DATE:___________________________**

Patient Name: ________________________ Date of Birth: _______________

Visitor Name: ________________________

TEMPERATURE READING by staff ___________	**P** ________ **PATIENT**	**V** _______ **VISITOR**
Are you FULLY Vaccinated for COVID?	YES NO	YES NO
In the past 10 days, have you had any of these symptoms?	YES NO	YES NO

- fever
- Shaking Chills
- Cough
- Shortness of breath
- CONGESTION
- New loss of taste or smell
- GI symptoms
- Fatigue
- Conjunctivitis
- Sore throat

In the past 10 days have you:

	PATIENT	VISITOR
● Been quarantined for suspected COVID-19?	YES NO	YES NO
● Been in close contact with a person who has a diagnosis of COVID-19 or who has symptoms?	YES NO	YES NO
In the past 10 days, have you been tested or told to get tested for COVID-19?	YES NO	YES NO

Date of test ______________________ RESULT________________________

Reason for testing:

- ☐ I have symptoms
- ☐ Surgical/Procedure clearance
- ☐ I was in the hospital
- ☐ Work related
- ☐ I wanted to get tested, even though I don't have symptoms
- ☐ Other: ________________________________

I agree to wear a face covering/mask covering my NOSE AND MOUTH while at Delmar Internal Medicine:

_________________________ _________________________ ________________

Patient signature Visitor signature DATE