Princeton Neurological Surgery

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COVID-19 Patient Screening Form

Date:_____/_____/_____
Month Day Year

Patient name: _____ **DOB:**_____/_____/_____
Last First Middle *Month Day Year*

Question:	**Patient response:**
Have you received the Covid vaccine; if so, present card upon arrival	☐ Yes ☐ No
Do you have a preexisting condition such as lung disease, heart disease, diabetes, kidney disease or an autoimmune disorder?	☐ Yes ☐ No
Are you experiencing shortness of breath or trouble breathing?	☐ Yes ☐ No
Do you have a temperature of 100.4° F or higher?	☐ Yes ☐ No
Are you experiencing a sore throat?	☐ Yes ☐ No
Are you coughing?	☐ Yes ☐ No
Are you experiencing repeated shaking with chills?	☐ Yes ☐ No
Do you have muscle aches?	☐ Yes ☐ No
Are you experiencing gastrointestinal changes?	☐ Yes ☐ No
Have you noticed a loss of smell or taste?	☐ Yes ☐ No
Have you had contact with a known or suspected COVID-19-positive person?	☐ Yes ☐ No
In the last 14 days, have you traveled to an area that has a high incidence of COVID-19?	☐ Yes ☐ No