OFFICE LETTERHEAD

HEALTH SCREENING

YES	NO	Are you exhibiting symptoms of acute respiratory illness (fever, cough, shortness of breath, etc.)?
YES	NO	Have you had close contact with a laboratory confirmed COVID-19 case?
YES	NO	Have you had or been in close contact with someone hospitalized with acute lower respiratory illness of unknown origin?
YES	NO	Do you have a history of travel to or from an affected geographic area with widespread community transmission?
YES	NO	Do you have a history of international travel or cruise within the past 4 weeks?
YES	NO	Are you immunocompromised?

Temperature: ______________

Name ____ Date ___________

Signature ____