kuhar medical

Internal Medicine • Cosmetic Services

COVID-19 Screening Questionnaire

Patient Name: _____

	Yes	No
Do you have a fever, or have you felt hot or feverish in the last 14 days?	☐	☐
Are you experiencing shortness of breath or unexplained cough?	☐	☐
Are you experiencing other flu-like symptoms, such as gastrointestinal upset, headache, or fatigue?	☐	☐
Have you recently experienced loss of taste or smell?	☐	☐
Are you in contact with anyone who has tested positive for COVID-19?	☐	☐
Have you been tested for/diagnosed with COVID-19? **If "yes," please indicate test date & result below.**	☐	☐

If you answered "yes" to any of these questions, please call our office to discuss with a member of our staff prior to your visit.

Patient Signature: _____ **Date:** _____