Bala Dermatology

COVID-19 Screening Questions

Name: _____

Date: _____

1. Have you received the COVID-19 vaccine? ☐ Dose 1 ☐ Dose 2
   a. Have you received your booster? _____
2. Have you personally received a **POSITIVE COVID-19 DIAGNOSIS?** ☐ YES ☐ NO
   a. If yes, when: _____
3. Have you had contact with anyone with a confirmed COVID-19 diagnosis **within the past 14 days**? ☐ YES ☐ NO
4. Have you experienced any of the following symptoms **in the past 14 days**: ☐ YES ☐ NO
   a. Fever greater than 100°F
   b. Difficulty breathing
   c. Cough
   d. Shortness of breath
   e. Loss of taste and/or smell

FOR OFFICE USE ONLY:

Temperature: _____