4/20/2020

Screening Questionnaire
Please Fill Out Completely

Date: _____ **Time**: _____

First Name: _____**MI**: _____ **Last Name:** _____

Reason for Visit: Patient/Visitor/Employee/Vendor

If visiting with patient, Patient Name: _____

"Welcome to Charlotte Surgery Center. To help protect the safety of our patients and staff, we are asking all patients and approved visitors to wear a mask. Do you have a mask or would you like me to provide one for you?"

SECTION 1	**Actual Temperature:_____**	
Temperature ≥ 100.1	No	Yes
SECTION 2 - Do you have any of the following symptoms:		
Recent/New Onset Coughing (not related to allergy or COPD)	No	Yes
Nasal Congestion (not related to allergies or sinus infections)	No	Yes
Recent/New Onset Sore Throat	No	Yes
Recent/New Onset Shortness of Breath (not related to chronic disease)	No	Yes
Recent/New Onset Diarrhea	No	Yes
Recent/New Onset Nausea/Vomiting	No	Yes
Recent/New Onset Fatigue/Malaise	No	Yes
Recent/New Onset of Loss of Taste/Smell	No	Yes
SECTION 3 - COVID-19 Exposure		
Are you living with someone that is quarantined or furloughed?	No	Yes
Have you been in contact with an individual positive for COVID-19?	No	Yes
Have you been in contact with a Person Under Investigation (PUI) COVID-19?	No	Yes
Are you considered a Person Under Investigation (PUI) COVID-19?	No	Yes
SECTION 4 - Personal COVID-19 Exposure		
Have you tested positive for COVID-19?	No	Yes