Center for Rheumatic Diseases & Osteoporosis
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Patient Name:_____ Date of Birth:_____

COVID-19 SCREENING QUESTIONNAIRE FOR IN-OFFICE APPOINTMENTS

Are you COVID-19 vaccinated? ☐ YES ☐ NO

Please check (✓) the box if you have had the following symptoms within the last 5 days:

- ☐ Fever
- ☐ Cough
- ☐ Diarrhea or stomach ache
- ☐ Sore throat
- ☐ Sore body or body aches
- ☐ Loss of taste
- ☐ Loss of smell
- ☐ Difficulty breathing
- ☐ Did you test positive for COVID-19? ☐ YES ☐ NO
  - If YES, when? _____
- ☐ Exposure to a confirmed COVID case within the last 5 days.
- ☐ None of the above.

I confirm the information mentioned above is true and correct.

_____ _____

Patient Signature Date