PLATINUM
PRIMARY CARE

Patient and Visitor COVID-19 Screen

Date:_____

Name:_____ Date of Birth:_____

We are committed to the health and safety of our patients and staff. All patients and visitors are asked to wear a mask and practice social distancing.

If you answer yes to any of the questions below, you may be directed to delay your visit.

Do you currently have a fever or chills, cough, shortness of breath, difficulty breathing, muscle or body aches, headache, new loss of taste or smell, sore throat, fatigue, congestion or runny nose, nausea, vomiting or diarrhea?

Please circle: Yes No

Are you required to self-quarantine for any of the following?

-Close, household exposure to someone with known or suspected COVID-19 in the last 14 days

-You tested positive, inconclusive or have test results pending for COVID-19 within the past 14 days.

-International, cruise ship or domestic travel from a location for which this state requires 14-day quarantine.

Please circle: Yes No