FIVESTAR Telehealth Clinic COVID-19 Screening

Name: _____DOB: _____/_____/_____

County of Residence: _____ Date Screened_____/_____/_____

Assessment Questions	**YES**	NO
Have you been in an area with known local spread of COVID-19 & not practicing social distancing?	☐	☐
Have you come in close contact (within 6 feet) with someone who has a laboratory confirmed COVID-19 Diagnosis in the last 14 days?	☐	☐
Have you come in close contact (within 6 feet) with someone who is experiencing symptoms and has been ordered to self-quarantine?	☐	☐

Do you have or have you had in the last 14 days:

Onset of symptoms: _____

- ☐ **Fever (greater than 100.4 F or 38.0 C)/Chills/Night Sweats** ☐ **Other:**
- ☐ **Lower respiratory illness such as cough**
- ☐ **Shortness of breath/Difficulty breathing**
- ☐ **Back Pain (Unusual)**
- ☐ **Loss of taste/smell**
- ☐ **GI symptoms (N/V/D)**
- ☐ **Chest pain/burning/pressure**
- ☐ **Headache/Sore throat/Nasal Congestion**
- ☐ **Other:_____**

☐ Schedule telehealth visit via phone app

☐ Telehealth visit in clinic

Comments:_____