Conscious Living
Create the life and world you want to live in!

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COVID-19 SCREENING MEDICAL HISTORY QUESTIONNAIRE

Date: _____

Client Name: _____

Please answer YES or NO:

Do you have a fever or above normal temperature? _____

Have you experienced shortness of breath or had trouble breathing? _____

Do you have a dry cough? _____

Do you have a runny nose? _____

Have you recently lost or had a reduction in your sense of smell? _____

Experiencing a metallic taste? _____

Do you have a sore throat? _____

Have you tested positive for COVID-19? _____

Have you been in contact w/ someone who tested positive for COVID-19?____

Have you been tested for COVID-19 and are awaiting results? _____

Have you traveled outside of the U.S. by air or cruise ship in the past 14 days? ____

Have you traveled within the U.S. by bus or train within the past 14 days? ____

We reserve the right to read your temperature as part of our screening protocol.

We are screening for: • Fever • Headache • Cough • Sore Throat • Shortness of breath • Recent loss of taste or smell • Chills • Contact with possible Covid-19 patients • Repeated shaking with chills • History of travel• Muscle pain• Temp greater than 100.4F

We are to keep a list of all patients and visitors to the office environment for contact tracing should it become necessary. This information may be requested by Public Health officials conducting a follow up contact tracing. If the practitioner or a staff member suspects they have been exposed to COVID-19 they will immediately be quarantined for a period of at least 2 weeks and notify any patients or other community members who may also be at risk from contact. If a patient has been confirmed as testing positive for COVID-19 and there is a risk of contamination to the practitioner or other patients, the practitioner will immediately contact patients at risk and enter into a quarantine for at least 2 weeks.

This form was created by Dr. Shannon May with NourishNaturalHealth.Com