Southern Crescent Family Practice LLC
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Forest Park GA 30297
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Pt Name: _____ **DOB:** _____ **Date:** _____

COVID-19 SCREENING

Please read and answer each question carefully.

1. Regardless of your vaccination status, have you experienced any of the symptoms in the list below in the past 48 hours? **YES** ☐ **NO** ☐

   - fever or chills
   - cough
   - sore throat
   - shortness of breath
   - body aches or headaches
   - loss of tasted or smell
   - nausea or vomiting
   - diarrhea

2. Have you traveled internationally in the last 10 days? **YES** ☐ **NO** ☐

3. Have you been in close physical contact in the last 10 days with anyone who is known to have COVID-19? **YES** ☐ **NO** ☐

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