Frederick Pediatric Associates

NAME: _____

DOB: _____

TODAY'S DATE: _____

COVID-19 SCREENING QUESTIONNAIRE

Have you, your child, or anyone in your household been exposed to a person who has tested positive for COVID-19?	Y	N
Have you or anyone in your household been tested for COVID-19? - If YES, did they test POSITIVE or NEGATIVE - Date Tested: _____	Y	N
Are you, or anyone in your household currently showing any possible symptoms of COVID-19? (fever, cough, shortness of breath, diarrhea, body aches, chills…)	Y	N
Have you or anyone in your household had any domestic or international travel within the last month?	Y	N