SUFFOLK SURGICAL ASSOCIATES, PC

COVID-19 SCREENING QUESTIONNAIRE

In response to the recent Coronavirus (COVID-19) outbreak and the raised pandemic alert status by the World Health Organization (WHO), Suffolk Surgical Associates, PC is taking precautions to lessen the spread of the virus. All patients must have a screening form completed.

	Yes	No
Has the patient or anyone in the family (household) tested positive for COVID-19?	☐	☐
Has the patient or anyone in the family (household) been tested for COVID-19 and are awaiting results?	☐	☐
Does the patient or anyone in the family (household) have any of the following respiratory symptoms? Fever, Sore Throat, Cough, Shortness of Breath?	☐	☐
Has the patient or anyone in the family (household) recently lost your sense of smell or taste?	☐	☐
Does the patient or anyone in the family (household) have any GI symptoms? Diarrhea? Nausea?	☐	☐
Even if you don't currently have any of the above symptoms, has the patient or anyone in the family (household) experienced any of these symptoms in the last 14 days?	☐	☐
Has the patient or anyone in the family (household) been in contact with someone who has tested positive for COVID-19 in the last 14 days?	☐	☐
Has the patient or anyone in the family (household) traveled outside the United States by air or cruise ship in the past 14 days?	☐	☐
Has the patient or anyone in the family (household) traveled within the United States by air, bus or train within the past 14 days?	☐	☐

- **If *answered YES to any of the above questions, a team member of Suffolk Surgical Associates, PC will reschedule your appointment. Please contact your MEDICAL DOCTOR for further advice.***

If you do not meet the criteria above, please sign below indicating that you have been provided with this information.

I HAVE REVIEWED THE ABOVE CRITERIA. I DO NOT HAVE SYMPTOMS AS DESCRIBED.

PATIENT NAME:_____DATE OF BIRTH:____/____/_____

SIGNATURE:_____DATE:_____