COVID-19 Screening Document.

Patient's name:
Date:

PREAPPOINTMENT CHECK – Please delete as appropriate and return before your appointment

Do you/they have fever or have you/they felt hot or feverish recently (14-21days)?	YES/NO
Are you/they having shortness of breath or other breathing difficulties?	YES/NO
Do you/they have a new continuous cough?	YES/NO
Any other flu like symptoms, such as gastrointestinal upset, headache or fatigue?	YES/NO
Have you/they experienced recent loss of taste or smell?	YES/NO
Have you/they been in contact with any conformed COVID-19 positive patients in the last 14days?	YES/NO
Are you/they over 70?	YES/NO
Do you/they have heart disease, respiratory problems, kidney disease, diabetes or any other auto-immune disorder	YES/NO