DARE TO EXCEL

TEXAS STAR

REHAB AND PERFORMANCE CENTER

COVID 19 Screening

(1 **) Do you have / have you experienced any of any of the following symptoms within last 15 days?** • Fever (>100.4F) • Myalgias • Respiratory symptoms (dyspnea or cough) • URI symptoms (headache, rhinorrhea, sore throat) • GI symptoms (diarrhea, nausea, vomiting) • ENT symptoms (loss of taste or smell) • Eye symptoms (conjunctivitis)	☐ YES Explain :	☐ NO
(2) Have you been in contact with someone who has tested positive for COVID-19 in the last 14 days?	☐ YES	☐ NO
(3) Have you been tested for COVID-19 in the last 14 days? If yes, what is the result of the testing?	☐ YES	☐ NO
(4) Have you traveled more than 100 miles from your home in the last 14 days?	☐ YES	☐ NO

Patient Name :_____

Patient Signature : _____

Date : _____