Texas Allergy & Breathing Centers

## SCREENING QUESTIONNAIRE FOR CORONAVIRUS DISEASE (COVID-19)

1. Have you traveled outside the US in the last 14 days? YES ☐ NO ☐

2. Do you (or anyone in your household) have any of the following symptoms? Fever, Coughing, and Shortness of Breath YES ☐ NO ☐

3. Have you had contact with anyone with confirmed COVID -19 in the last 14 days? YES ☐ NO ☐

4. Are you currently experiencing fever over 100F, difficulty breathing, or coughing? YES ☐ NO ☐

**Patient Signature**: _____ **Date**: _____