Central Virginia Neurology, PLC Screening Questions

Have you had a fever within the last 14 days? YES or NO

Have you had a new or worsening cough or shortness of breath within the past 14 days? Yes or NO

Have you had any flu-like symptoms in the past 14 days, such as GI upset, headache, fatigue or muscle aches? YES or NO

Have you had a loss of taste or smell? YES or NO

Have you had contact with a person testing positive for Covid-19 or who has been exposed to it in the last 14 days? Yes or NO

Current temperature? _____

_____ _____

Signature Patient name

_____

Date