Naugatuck Valley ent Ear, Nose & Throat Associates LLC

COVID-19: Screening Questions

Patient Name: _____

1. Do you have any of the following?
   - ☐ Fever (100 F or greater)
   - ☐ Shortness of breath (not severe)
   - ☐ Cough
   - ☐ Chills
   - ☐ Repeated shaking with chills
   - ☐ Muscle pain
   - ☐ Headache
   - ☐ Sore throat
   - ☐ New loss of taste or smell

2. Are you ill, or caring for someone who is ill?

3. Have you had recent contact with someone diagnosed with COVID-19? (If, you are a healthcare worker and have come in contact with a COVID positive patient without proper PPE, you must answer yes to this question. If you are a healthcare worker and have come in contact with a COVID positive patient but had appropriate PPE, then you can answer no to this question.)

4. Have you recently traveled to any states that have a higher that 10% infection rate?

_____ _____

Signature Date