Stephens County Hospital

COVID-19 Pre-Appointment Screening Questionnaire

Please bring this with you to your appointment

1. Are you currently having signs or symptoms of COVID-19?

   ☐ Yes ☐ No ; if Yes, please check which symptoms apply:

   ☐ Fever ☐ Cough ☐ Difficulty Breathing

   ☐ Headache ☐ Nausea ☐ Stomach Pain

   ☐ Other: _____

2. Have you been in direct contact with anyone who currently has, or is suspected of having, COVID-19?

   ☐ Yes ☐ No

3. Have you recently traveled?

   ☐ Yes ☐ No

4. Have you recently been in a large group setting where masking and/or social distancing were not enforced?

   ☐ Yes ☐ No

5. Do you have any other reason or suspicion for thinking you may have COVID-19?

   ☐ Yes ☐ No ; if Yes, please describe:

   _____

   _____

If you answered "Yes" to any of the above questions, please call the office when you arrive for your appointment. DO NOT enter the office without calling in advance. We will meet you at your car.

Thank you for choosing Stephens County Hospital