MEDICAL DAYSPA
CHAPEL HILL

Provider: _____

Date & Time of Appt: _____

Patient Screening: COVID-19

Patient Information

Patient Name: _____ DOB: _____ Date: _____

Please answer Questions (Yes or No)

Question #1: In the past two (2) weeks, have you had any of the following symptoms?

- Cough ☐ Yes ☐ No
- Shortness of breath or difficulty breathing ☐ Yes ☐ No
- Fever and/or chills or repeated shaking w/ chills ☐ Yes ☐ No
- Muscle Pain ☐ Yes ☐ No
- Headache ☐ Yes ☐ No
- Sore Throat ☐ Yes ☐ No
- Vomiting or diarrhea ☐ Yes ☐ No
- New loss of taste or smell ☐ Yes ☐ No

Question #2: Have you had contact with anyone with confirmed COVID-19 in the last 14 days? ☐ Yes ☐ No

_____

Question #3: Have you traveled outside of North Carolina in the past 14 days? ☐ Yes ☐ No

_____

RN TO COMPLETE THIS SECTION

Temperature: _____

RN Notes:

_____

_____

_____

RN Initials: _____