



VIRAL ILLNESS/COVID SCREENING QUESTIONNAIRE

PATIENT NAME _____ DATE: _____

Height: _____ Weight: _____ Age: _____ BP: _____ Pulse: _____ RR: _____ O2% _____

- 1. Have you had a fever >101, or felt feverish lately?
- 2. Have you had a new or different type cough lately?
- 3. Have you had shortness of breath, difficulty breathing?
- 4. Any chills or repeated episodes of shaking with chills?
- 5. Any daytime sweats unrelated to exercise, or night sweats?
- 6. Any nausea, GI upset, vomiting or diarrhea?
- 7. Have you had recent loss of taste or smell?
- 8. Do you have new or different muscle/joint aches?
- 9. Have you felt loss of energy, or severe fatigue lately?
- 10. Have you had trouble with focus, memory or concentration?
- 11. Have you had any other flu-like symptoms?
- 12. Have you lost appetite and or lost weight?
- 13. Any travel to COVID-19 areas in last 14 days?
- 14. Any contact within last 14 days with someone who tested positive for COVID-19? If so, when? _____
- 15. Have you tested positive for COVID-19? When _____
- 16. Have you been clinically diagnosed with COVID-19?



RISK FACTORS CHECKLIST: DO YOU HAVE ANY OF THESE CONDITIONS?

- Obesity, Heart disease, history of heart attack, arrhythmias, high blood pressure, TIA, or stroke? (Circle any that apply)
- lung disease? (COPD, asthma, pulmonary fibrosis, CF, other?)
- Kidney disease? Type: _____
- Diabetes, Metabolic Syndrome/Insulin Resistance?
Are you taking insulin? Yes: _____ No: _____
- Any kind of cancer, undergoing treatment?
- Any type of autoimmune disease?
- Do you regularly take corticosteroid medicines?

COVID TREATMENT FLOW SHEET INITIAL SERVICE

	DAY	1	3	5	7	COMMENTS
1	Fever or chills . 100° F or higher.					
2	Cough					
3	Shortness of breath					
4	Fatigue					
5	Muscle or body aches					
6	Headache					
7	New loss of taste or smell					
8	Sore throat					
9	Congestion or runny nose					
10	Nausea or vomiting					
11	Diarrhea					
12	Pulse rate					
13	Side effects					