



Total Pain & Spine Care of Florida

COVID-19 Screening Questionnaire

Due to worldwide healthcare concerns over the Novel Coronavirus (COVID-19) and in an effort to protect patients and staff, we will be asking all patients to complete a screening form for symptoms of potential exposure to Novel Coronavirus (COVID-19) prior to their appointment. Based on the responses from the screening form, patients may be asked to reschedule their visit.

Complete temperature screening with infra-red thermometer at front entrance.	Temperature at time of arrival:	
Have you been tested for COVID-19 in the past 14 days and is pending results?	Date:	
Circle Yes or No to the following questions:		
Fevers	YES	NO
Myalgias (fatigue)	YES	NO
Respiratory symptoms (shortness of breath or cough)	YES	NO
URI symptoms (headache, rhinorrhoea, sore throat)	YES	NO
GI symptoms (diarrhea, nausea, vomiting)	YES	NO
ENT symptoms (loss of taste or smell)	YES	NO
Eye symptoms (conjunctivitis)	YES	NO
Have you travelled internationally in the last 14 days?	YES	NO
Have you travelled in an airplane or on a cruise ship in the last 14 days?	YES	NO
Have you visited or do you reside in a community with confirmed community spread of COVID-19?	YES	NO
Have you been exposed to anyone who has tested positive or is under investigation for COVID-19?	YES	NO

Patient Name: _____

Appointment Date: _____

Date of Screening: _____

Staff Name: _____