surgical associates p.a.

Place Patient Label Here

COVID-19 (Coronavirus) Patient Travel Screening

1. Have you traveled outside the state of Kansas in the last 14 days? ☐ **Yes** ☐ **No**

   If yes: Where: _____ When: _____

2. Have you traveled internationally within the past 14 days? ☐ **Yes** ☐ **No**

   If yes: Where: _____ When: _____

3. Have you had contact with anyone in the past 14 days who has been quarantined or isolated for COVID-19? ☐ **Yes** ☐ **No**

4. Have you been tested for COVID-19? ☐ **Yes** ☐ **No**

   If yes: When: _____ Results: _____

5. Do you **currently** have any of the following symptoms? ☐ **Yes** ☐ **No**

   (Please check box for all that apply)

   ☐ Lower respiratory illness (including cough, shortness of breath, or difficulty breathing)

   ☐ Fever (100.4F or above) last 24 hours ☐ Sore throat ☐ Chills

   ☐ Diarrhea ☐ Loss of smell, or change or loss of taste sensation

   ☐ Muscle pain ☐ Malaise (general body weakness) ☐ Rigors (shivering)

_____ _____

Patient Signature Date