**COVID-19 Health Screening**

Patient Name: Enter First Name here Enter Last Name here

Date of Birth: Enter Date of Birth here

Therapy Location: Click here to choose a location. Select from the dropdown.

Today’s Date: Click or tap to enter a date.

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| --- | --- |
| Have you tested positive for COVID-19 in the past 3 weeks or do you have a test pending? | [ ]  Yes [ ]  NoIf YES provide date of diagnosis/test Click to enter date. |
| Have you had contact with someone under investigation for, or infected with, COVID-19 in the past 10 days without wearing personal protective equipment? | [ ]  Yes [ ]  No |
| Unrelated to existing medical condition do you have any one of the following symptoms? | [ ]  Fever (Temp >100.00) or feeling feverish (chills with muscle aches)[ ] New cough[ ]  New difficulty breathing[ ]  New Vomiting or diarrhea[ ]  New loss of sense of  taste or smell [ ]  New Sore throat[ ]  New Congestion or runny nose[ ]  NONE OF THE ABOVE  |

Return this Health Screening to GSPP.PatientForms@pennmedicine.upenn.edu or call ***877-969-7342***