**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  No  If 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](mailto:GSPP.PatientForms@pennmedicine.upenn.edu) or call ***877-969-7342***