IMMEDIATE CARE SM
a service of HATTIESBURG CLINIC

Name: _____

Date of Birth: _____

History #: _____

Physician: _____

LABEL

COVID - 19 Screening Questionnaire

1. Are you here today because you feel you need to be tested for COVID-19? Yes____ No_____

2. Have you been vaccinated for COVID-19? Yes____ No_____
   Pfizer_____ Moderna_____J& J_____ Date of last shot_____
   Have you had the COVID-19 booster shot? Yes____ No ____
   Pfizer_____ Moderna_____ Date of booster_____
3. Have you been previously diagnosed with COVID-19? Yes___ No___ When_____
4. Have you had recent exposure to someone with COVID-19? Yes___ No___ When?_____

TEMP____O2Sat_____Pulse____Resp____

In the past 5 days, have you had the following symptoms? (MD go out)

____	Fever or Chills	**(If answer "YES" to any questions)**
____	Sinus congestion or drainage	Name _____New ___Est___
____	Cough or Wheezing	DOB_____
____	Shortness or breath	Phone_____
____	Body aches	Make/Model Vehicle_____
____	Severe headaches	_____
____	Loss of taste or smell	Insurance? ____ or Self pay? ____
____	Sore throat	Name of Insurance _____Copay$____
____	Diarrhea	Iris? Yes___ No___

***When did symptoms begin?* _____**

*******(To be completed by patient or guardian) ********

____Yes ____No - Is Covid testing for preoperative screening?
____Yes ____No - Is testing for placement in another facility or required screening?
____Yes ____No - Is this 1st COVID test (If no was any previous test positive ___Yes ___No)?
____Yes ____No - Employed in healthcare? If so, Hattiesburg Clinic employee ___Yes ___No?
____Yes ____No - Are you having any symptoms?
____Yes ____No - Have you been hospitalized due to COVID 19?
____Yes ____No - Are you a resident in a group home?
____Yes ____No - Are you pregnant?

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(6/2021)