Patient Screening Questions

Do you have a fever or have you felt hot or feverish recently (14-21 days)? Yes or No

Are you having shortness of breath or other difficulties breathing? Yes or No

Do you have a cough? Yes or No

Do you have any other flu-like symptoms, such as gastrointestinal upset, headache, or fatigue? Yes or No

Have you experienced recent loss of taste or smell? Yes or No

Are you or have you been in contact with any confirmed COVID-19 positive patients? Yes or No

Is your age over 60? Yes or No

Do you have heart disease, lung disease, kidney disease, diabetes, or any auto-immune disorders? Yes or No

Have you traveled in the past 14 days to any regions affected by COVID-19? Yes or No