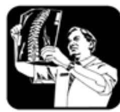

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210 Old Bridge Street, East Syracuse, NY 13057
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315-445-9941 ★ Fax 315-445-2073

COVID QUESTIONNAIRE

Patient Name:	Date:

Self-Declaration by Patient Please Mark with an X in the box that applies

Today or in the past 24 hours, have you had any of following symptoms?	**YES**	**NO**
Fever (100.4°/38° C or higher), felt feverish, or had chills?		
New or worsening persistent (frequent or continuing) cough?		
New or worsening difficulty breathing?		
Have you traveled to People's Republic of China (mainland), Schengen Area, Austria, Belgium, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungry, Iceland, Italy, Latvia, Liechtenstein, Lithuania, Luxembourg, Malta, Netherlands, Norway, Poland, Portugal, Slovakia, Slovenia, Spain, Sweden, Switzerland, Monaco, San Marino, Vatican City, Iran, Ireland, Scotland, United Kingdom or any other parts of the country not listed above? If not listed please list, ____		
Have you traveled to New York City, The Bronx, Staten Island, Queens, Brooklyn, Manhattan and the surrounding New York Counties?		
Have you had close contact with or cared for someone diagnosed with COVID-19 within the last 14 days?		
If yes, please provide explanation and documentation.		
Have you had a COVID-19 Vaccine? If Yes, Date: ___/___/_____ Which Vaccine did you have? ___________________________		

Patient answering YES to any of the above questions may not be permitted to access this facility.

Patient Signature:	Date:
Temperature of patient:____________________	

STAFF ONLY

Does patient have any visible signs of cough or shortness of breath or being obviously unwell?		

Notes:	
Reviewed by:	Date: