Capstone Healthcare 2019 Novel Coronavirus (COVID-19),

Perioperative and Procedural COVID-19 Screening Form

Name: Date of Birth

Sex: Male Female Phone Number:

Address:

Date Symptoms Began:

Any Known Respiratory or Immune Medical Conditions? Yes No

If yes, please describe:

Have you been in contact with someone who was sick? (Select One)

Yes	
No / Unsure	
Unable to Assess	

Does the patient have any of the following symptoms? (Select all that apply)

None of these	
Cough	
Muscle Pain	
Shortness of Breath	
Unable to assess	
Diarrhea	
Rash	
Vomiting	
Abdominal Pain	
Fever Greater than 100F or 37.8	
Red Eye	
Weakness	
Bruising or Bleeding	
Joint Pain	
Severe Headache	
Loss of Smell	
Loss of Taste	

Other:

Travel History

Has the patient traveled outside of state in the past 14 days?	Yes No
If so, where did they travel?	
If So, what dates did they travel?	

CAPSTONE HEALTHCARE

April 2, 2020