Patient Name:_____ Date:_____ Temp:_____

KISS AESTHETICS
BY KIM BURKE

COVID 19 SCREENING QUESTIONNAIRE

1) Have you had an **exposure** to anyone that has confirmed + COVID 19 in the past 14 days? Y N

2) Have you had a **fever** in the past 14 days? Y N

3) Do you currently have any **body aches**? Y N

4) Have you **travelled outside the US** in the past 14 days? Y N

5) Do you have a **cough** currently? Y N

6) Do you have any **shortness of breath**? Y N

7) Do you have **chills**? Y N

8) Do you have **sore throat** currently? Y N

9) Do you have current **headache**? Y N

10) Do you have any new **loss of taste or smell**? Y N

Source: https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html