Forte Family Practice **COVID-19** Preliminary Screening Form

Date: _____

Name: _____ DOB: _____
(Please print)

Temperature: _____

Fever in the last 14 days? ☐ Yes ☐ No

Have you traveled outside of the United States in the past 14 days?

☐ Yes ☐ No Where? _____

Do you have or have you had a cough or shortness of breath in the last 14 days?

☐ Yes ☐ No

For more information:
www.cdc.gov/coronavirus