SOUTHERN FAMILY MEDICINE LLC
Primary care for patients of all ages

16312 Mount Airy Road
Shrewsbury, Pennsylvania 17361
www.SouthernFamilyMed.com

Phone (from PA): (717) 227-3800
Phone (from MD): (410) 584-2600
Fax: (717) 227-3802

COVID-19 Pre-Appointment Screening Questionnaire

*****Please explain any "YES" answers on the back of this form. A positive response to any of these questions may require further discussion with your doctor before your visit.*****

Have you or anyone in your household had any of the following symptoms in the last 7 days?

Yes	***No***	
☐	☐	**Fever (temperature over 100.4°F)**
☐	☐	**New onset or worsening cough**
☐	☐	**Loss of smell or taste**
☐	☐	**New onset of shaking/chills**
☐	☐	**New onset or worsening sore throat**
☐	☐	**New onset runny nose/sinus symptoms – not related to allergies**
☐	☐	**New onset body aches or muscle aches**
☐	☐	**New onset or worsening of shortness of breath**
☐	☐	**New onset or worsening nausea or vomiting**
☐	☐	**New onset or worsening diarrhea**
☐	☐	**New onset or worsening headache**
☐	☐	**New onset unusual or extreme fatigue**
☐	☐	**If you have COPD/asthma/chronic cough, has there been any recent change or worsening of your symptoms in the last week?**
☐	☐	**Have you tested positive for COVID-19 in the last 14 days?**
☐	☐	**Have you or anyone in your household cared for an individual who is in quarantine or has tested positive for COVID-19 in the last 14 days?**
☐	☐	**Have you had close contact with anyone who tested positive for COVID-19 in the last 14 days?**
☐	☐	**Have you received the COVID-19 vaccine? *(please provide vaccination card)***

If you have, please provide the type of vaccine you received and the dates you received the vaccine.

COVID Vaccine Brand (circle one): *Pfizer* *Moderna* *Johnson & Johnson*

1st Vaccine Date: _____ *2nd Vaccine Date:* _____

☐ **I agree that I have answered all questions to the best of my knowledge:**

Patient Name Signature Date