COVID-19 Screening Form

Appointment Date: _____ Time: _____

Work/Connection: _____

Name of Interviewer: _____ Date form completed : _____

Contact Information for caller:

1. Person Name : _____ Phone Number: _____
2. Male or Female (circle one) a. Date of Birth: _____
3. Relationship of person answering questions for contact or traveler if not them: ☐ Self Other: _____
4. Address: _____ Will they be at this address next 14 days? Yes /No
5. If not where will they be? _____
6. County of residence: _____ Is this a **Re-test**? ☐ Isolation Protocol: 1st 2nd Other
7. State of Residence: _____ ☐ Re-exposure (Minimum of 6 days from exposure)
8. Language: ☐ English ☐ Spanish ☐ Other: _____ Re-Exposure Date: _____
9. Ethnicity: ☐ White ☐ Black ☐ Hispanic ☐ American Indian ☐ Asian ☐ Other: _____
10. Insurance Information:

Insurance Type: _____

Subscriber Name/DOB: _____

☐ **No Insurance**

☐ **Macon Co. Employee**

☐ **Dependent of Macon Co. Employee**

Relationship to Subscriber (circle one): Self Spouse Child

Subscriber Information (If not self):

Name: _____ DOB: _____

Address (if different from self): _____

Policy ID: _____ Policy Group #: _____

For women: Are you currently pregnant? No Yes Don't Know

Have you been around individuals known to have COVID? Yes No

If yes, who and type of exposure: _____

Do you have symptoms of illness? YES NO If yes, when did symptoms start? _____

During this illness, have you experienced any of the following:		**Symptom Present?**		
Fever >100.4F (38C)c	Subjective fever (felt feverish)	Yes	No	Unknown
Chills	Muscle aches	Yes	No	Unknown
Runny nose (rhinorrhea)	Sore throat	Yes	No	Unknown
Cough (new onset or worsening of chronic cough)		Yes	No	Unknown
Shortness of breath (dyspnea)		Yes	No	Unknown
Nausea, Vomiting, Diarrhea, Abdominal Pain		Yes	No	Unknown
Headache		Yes	No	Unknown

Other, specify: _____

Pre-existing medical conditions? Circle one: Yes No Unknown

Lung Conditions: Asthma Emphysema COPD	Yes	No	Unknown	
Diabetes Mellitus	Yes	No	Unknown	
Heart Disease/Conditions	Yes	No	Unknown	
Renal or Liver Conditions	Yes	No	Unknown	
Any condition that would make you Immunocompromised ?	Yes	No	Unknown	
Neurologic conditions? Stroke Seizures	Yes	No	Unknown	If YES:
Other chronic diseases	Yes	No	Unknown	If YES:
Current smoker Former Smoker	Yes	No	Unknown	
Any other chronic condition?	Yes	No	Unknown	

Household contact (names and ages) :

_____

_____

_____

Notes/ Remarks:

_____

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_____

Date: 6/9/2020 - JR