PRECISION VASCULAR ACCESS

COVID Screening Tool

Please answer "Yes" or "No" to the following:

1. Do you or any one in your household currently have a fever or felt hot/feverish recently or within the last 14-21 days?

   ☐ Yes ☐ No

2. Do you or any one in your household have shortness of breath or other difficulties breathing?

   ☐ Yes ☐ No

3. Do you or anyone in your household currently have a cough?

   ☐ Yes ☐ No

4. Do you or anyone in your household have any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?

   ☐ Yes ☐ No

5. Have you or anyone in your household recently experienced loss of taste or smell?

   ☐ Yes ☐ No

6. Have you or anyone in your household traveled within the last 14 days to any regions affected by COVID-19?

   ☐ Yes ☐ No

Please explain any questions answered with a "yes" above:

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