ADVANCED RADIOLOGY

Novel Coronavirus (COVID-19) Screening Questionnaire

Patient Name: _____ DOB: _____

Please Circle **YES** or **NO** to the following questions:

1. Have you traveled outside the USA in the last 14 days?

   YES NO

2. Have you, or anyone else who lives with you traveled to China, Italy, Japan, North Korea, or any parts of Asia within the past month?

   YES NO

3. Have you been in close contact with anyone who has traveled to these areas in the past month?

   YES NO

4. Have you been in close contact with a person known to have 2019 Novel Coronavirus (COVID-19)?

   YES NO

5. Do you, any member of your household, or anyone traveling with you today have flu-like symptoms which may include fever, cough, or shortness of breath?

   YES NO

Signature of person completing this questionnaire: _____

Patient or Guardian Signature: _____

Relationship to patient/minor (if applicable): _____ Date: _____