GREATER PORTLAND HEALTH

CARING FOR THE WHOLE COMMUNITY

Patient Name: _____

Patient Date of Birth: _____

Please circle yes or no for each question

1.) Do you currently have a fever? YES or NO

2.) Have you had a fever in the last 14 days? YES or NO

3.) Do you currently have a cough? YES or NO

4.) Have you had a cough in the last 14 days? YES or NO

5.) Have you traveled outside of the United States in the last 14 days? YES or NO

If so, where did you travel to/from?_____

6.) Have you been exposed to anyone that has been diagnosed with the Coronavirus (COVID-19) that you are aware of? YES or NO

Applicable as of March 4, 2020