Neurology Center of Fairfax
3020 Hamaker Court, Suite 400
Fairfax VA 22031

COVID 19 Screening

Patient Name: _____ Date: _____TEMPERATURE: ___

	YES	NO
Regardless of your vaccination status: In the last 48 hours have you or any member of your household had any of the following symptoms:		
• Temperature over 100F/ Chills?	☐	☐
• Cough/ Sore Throat/Runny nose?	☐	☐
• Shortness of breath?	☐	☐
• Loss of taste or smell?	☐	☐
• GI upset: diarrhea, nausea, and/or vomiting?	☐	☐
• Muscle or body aches	☐	☐
Have you or a member of your household been in close contact with or cared for someone with Covid-19 or symptoms of Covid-19 in the past 10 days?	☐	☐
Have you or a member of your household had a **positive** COVID-19 test within the last 10 days?	☐	☐
Have you or a member of your household received treatment in a hospital, emergency room or urgent care center in the past 10 days?	☐	☐
Do you live in or have you visited an assisted or independent living facility, group home, or nursing home in the past 10 days?	☐	☐
Have you travelled to a country outside the USA or have you been exposed to someone who has travelled to a country outside the USA in the past 10 days?	☐	☐
Do you have any reason to believe you may have an active COVID-19 infection?	☐	☐

Have you been fully vaccinated? **YES**☐ **NO**☐ **BOOSTER VACCINE? YES**☐ **NO**☐

Patient Signature: _____