PATIENT / VISITOR
COVID-19 SCREENING FORM

All Patients and Visitors will be asked the following questions for the safety of all:

1. In the last 14 days, have you traveled outside the state of Montana?	❒ Yes ❒ No
2. If "Yes" where?	
3. When did you arrive in Montana?	
4. Have you been tested for COVID-19 or been in contact with someone who has been diagnosed with COVID-19?	❒ Yes ❒ No
5. ✶ Are you experiencing ANY of the following symptoms:	
a) Cough	❒ Yes ❒ No
b) Fever of 100.0 or higher (check temperature)	❒ Yes ❒ No
c) Shortness of breath or difficulty breathing	❒ Yes ❒ No
d) Chills	❒ Yes ❒ No
e) Muscle pain	❒ Yes ❒ No
f) Sore throat	❒ Yes ❒ No
g) New loss of taste or smell	❒ Yes ❒ No