ALL NEUROLOGICAL SERVICES, P.C.
IGOR KHELEMSKY, M.D.
Diplomate of the American Board of Psychiatry and Neurology

CORONAVIRUS SCREENING

NAME: ______________________________

DATE: ______________________________

	QUESTION	RESPONSE
1.	Have you experienced any of the following symptoms within the last month? (Fever, cough, shortness of breath, severe fatigue, body aches, sore throat)	☐ YES ☐ NO
2.	Have you traveled outside if the country in the last month?	☐ YES ☐ NO
3.	Have you tested positive for Coronavirus?	☐ YES ☐ NO
4.	Have you been in close contact with a person who has tested positive for Coronavirus?	☐ YES ☐ NO
5.	Have you or a member of your household been treated in a hospital for any reason in the last 30 days?	☐ YES ☐ NO