ADVANCED
SURGICAL GROUP

# COVID-19 Screening

**Have you experienced any of the following symptoms in the past 48 hours?**

☐ YES ☐ NO

- Fever or chills
- New or unexplained onset of cough, shortness of breath, or difficulty breathing
- New or unexplained loss of taste or smell
- New or unexplained muscle aches

_____

Patient Name

_____ _____

Patient Signature Date