Millennium Physicians Association, PLLC

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Internal Medicine COVID-19 Screening

Patient Name: ____

DOB: _____/_____/______

Have you or anyone you have been in contact with had any of following symptoms in the last 6 weeks:

Yes/No   Fever (>100.4F or >38.0C)

Yes/No   Respiratory illness (cough, shortness of breath)

Yes/No   GI symptoms (diarrhea, nausea and vomiting)

Yes/No   High risk travel in the last 14 days (out of state travel)

Yes/No   Exposure to anyone with known or suspected COVID-19

Have you been tested for COVID? (If yes, please select one below)

___ Antigen   Positive/ Negative

___ Antibody   Positive/ Negative

To ensure your safety and that of our staff please follow the following rules outlined by the CDC

- Bring your own mask (people without a mask will not be seen)
- Be on time to your appointment to minimize the amount of time spent in the waiting area
- Sit at least 6 feet apart from other people

Patient Signature: ________________________________

Date: __________________________________

***If you tested positive or marked yes to any of the above symptoms you are not a candidate to be seen in clinic; however, you may still be seen via a telemedicine appointment through FaceTime or Zoom.**

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