Dr. Graham's Office Screening for Patients

1. Do you have a fever, or have you felt feverish?
2. Do you have a cough?
3. Are you short of breath, or any difficulty breathing?
4. Do you have repeated chills or repeated shaking with chills?
5. Do you have any muscle pain that is new?
6. Do you have a sore throat or recurrent headaches?
7. Do you have any flu like symptoms?
8. Have you been around any individual who has had these symptoms or tested positive for COVID-19?
9. If so, how long has it been since you have been in contact with them?
10. Have you been in practicing social distancing?
11. Do you wear a mask when you are out of the house routinely?
12. If you work out of the household, do you wear your mask in order to maintain social distancing?
13. Have you had the COVID virus?
    a. If yes, have you been tested Were you hospitalized?
        i. If so, when were you released?
        ii. Are there any long term effects?
14. Have you been ever been tested for COVID?
    a. If so when?
        i. Results
15. Have you been ever tested for the antibodies?
    a. If so when?
        i. Results
16. Are you over 65?
    a. Do you have:
        i. Heart disease
        ii. Lung disease
        iii. Kidney disease
        iv. Diabetes
        v. Autoimmune disorders