

Integrative Medical Associates

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Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**COVID-19 SCREENING QUESTIONNAIRE**

Please answer ‘Yes” or “No” to the following questions:

Are you currently awaiting the results of a COVID-19 test? Yes No

Have you been exposed to someone suspected of having COVID-19? Yes No

Do you have a fever? Yes No

Do you have any shortness of breath, dry cough, runny nose, sore throat? Yes No

Within the last 21 day, have you traveled to any foreign country? Yes No

If so, when and where?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Within the last 21 days, have you traveled within the United States? Yes No

If so, when and where?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_