Healthcare Facility Visitor Health Screening Questionnaire

Please complete this screening questionnaire before entering the healthcare facility. This form is used to ensure the safety of all patients, staff, and visitors.

1. Visitor Information

Date (MM/DD/YYYY):

Time of Entry:

Full Name:

Phone Number:

Email Address:

Patient Name Visiting (If applicable):

Relationship to Patient:

---

2. Symptom Screening

Please indicate if you are currently experiencing any of the following symptoms (Write "Yes" or "No"):

Fever or chills (100.4Â°F/38Â°C or higher):

Cough or sore throat:

Shortness of breath or difficulty breathing:

New loss of taste or smell:

Muscle aches, body aches, or unusual fatigue:

Nausea, vomiting, or diarrhea:

---

3. Exposure History

Please answer the following questions (Write "Yes" or "No"):

Have you been in close contact with anyone diagnosed with an infectious disease (e.g., COVID-19, Influenza) in the past 10 days?

Have you been directed to self-isolate or quarantine by a healthcare provider or public health official?

4. Acknowledgement and Signature

By signing below, you certify that your answers are true and correct to the best of your knowledge.

Visitor Signature (Sign on line):

Date Signed:

For Facility Use Only

Screening Staff Name:

Screening Decision (Approved / Denied):

Staff Signature: