Peak
Heart & Vascular

COVID-19 PATIENT SCREENING

Have you been tested for COVID-19 in the past 14 days?

YES ☐ NO ☐

If yes, what was the result of the test?

POSITIVE ☐ NEGATIVE ☐

Have you been in contact with someone who has tested positive for COVID-19 in the last 14 days?

YES ☐ NO ☐

Have you or anyone in your immediate family/household had contact with anyone who has traveled internationally?

YES ☐ NO ☐

Have you or any family/household members had any of the following symptoms:

YES ☐ NO ☐ Cough
YES ☐ NO ☐ Shortness of Breath
YES ☐ NO ☐ Chills
YES ☐ NO ☐ Muscle Pain
YES ☐ NO ☐ Headache
YES ☐ NO ☐ Sore Throat
YES ☐ NO ☐ Reduction / Loss of Taste or Smell

Patient Name: _____ Temperature: _____

Signature: _____ Date: _____

main 602-698-PEAK (7325) | fax 480-500-8430
info@peakheart.com | peakheart.com