Mount Sinai

INFECTIOUS DISEASES SCREENING TOOL

Please answer all of the below questions.
This information will help us keep our patients and staff safe.

1. Have you or a close contact* been diagnosed with COVID-19 and/or have you been asked to quarantine in the past 14 days?	□ Yes	□ No
2. Do you have a fever or chills?	□ Yes	□ No
Do you have cough, shortness of breath or sore throat?	□ Yes	□ No
Do you have body / muscle aches?	□ Yes	□ No
Do you have a new loss of taste or smell?	□ Yes	□ No
Do you have loss of appetite, vomiting or diarrhea?	□ Yes	□ No
Do you have a rash?^	□ Yes	□ No
3. Have you had close contact* with a person with Ebola/Lassa/Marburg, Measles, Middle Eastern Respiratory Virus (MERS), Mumps, Chickenpox or any other known infectious disease in the last 21 days?	□ Yes	□ No
4. Have you or a household member traveled outside the U.S. in the past 21 days (3 weeks)? If yes, where _____	□ Yes	□ No

If you answer "yes" to Question 1, 2 or 3, please alert a staff member immediately

* Close contact is defined as someone the patient spent ≥15 minutes within 6 feet of AND either the patient or the contact was not wearing a mask
^ Rash is not typical with COVID-19 but is a sign of other infectious diseases such as chickenpox or measles.