PATIENT NAME AND DOB:____

DATE: ____________________

TEMPERATURE: ____________________________

DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS:

- RECENT / NEW ONSET OF COUGHING (NOT RELATED TO ALLERGIES OR COPD) YES OR NO
- NASAL CONGESTION (NOT RELATED TO ALLERGIES OR SINUS INFECTION) YES OR NO
- RECENT/NEW ONSET OF SORE THROAT OF CHILLS YES OR NO
- NEW ONSET OF HEADACHES YES OR NO
- RECENT/NEW ONSET OF SHORTNESS OF BREATH YES OR NO
- RECENT/NEW ONSET OF DIARRHEA YES OR NO
- RECENT/NEW ONSET OF NAUSEA /VOMITING YES OR NO
- RECENT /NEW ONSET OF FATIGUE/MALAISE YES OR NO
- RECENT/NEW ONSET OF LOSS OF TASTE/SMELL YES OR NO

COVID 19 EXPOSURE:

- ARE YOU LIVING WITH SOMEONE THAT IS QUARANTINED YES OR NO
- HAVE YOU BEEN IN CONTACT W/ AN INDIVIDUAL POSTIVE FOR COVID YES OR NO
- HAVE YOU BEEN IN CONTACT W/ A PERSON UNDER INVESTIGATION FOR COVID YES OR NO
- ARE YOU CONSIDERED A PERSON UNDER INVESTIGATION FOR COVID YES OR NO
- HAVE YOU TESTED POSITIVE FOR COVID YES OR NO

PATIENT SIGNATURE:____