CORONAVIRUS QUESTIONNAIRE

Patient Name: _____ **Date:** _____

Patient DOB: _____

1) Have you had any of these symptoms in the past 14 days? Fever, cough, shortness of breath, sore throat. chills, loss of taste or smell? Do you live with someone that has these symptoms?

▫ YES ▫ NO

2) Have you had direct contact with someone that tested positive for COVID 19 in the past 14 days?

▫ YES ▫ NO

3) Have you been diagnosed with COVID 19 in the past 14 days?

▫ YES ▫ NO

4) Have you traveled in the past 14 days?

▫ YES ▫ NO

If YES, please specify where:

_____

_____

_____

_____

5) Have you been social distancing and wearing a mask when you go out of your home over the past 14 days?

▫ YES ▫ NO