COVID-19 QUESTIONNAIRE

PATIENT NAME _____

1. Have you tested positive for COVID-19? YES___ NO ___

2. Have you been tested for COVID-19 and are awaiting results? YES ___ NO___

3. Do you have any of the following respiratory symptoms? Fever, Sore Throat, Cough, Shortness of Breath? YES____ NO ____

4. Have you recently lost your sense of smell or taste? YES____ NO ____

5. Do you have any GI symptoms? Diarrhea? Nausea? YES____ NO____

6. Even if you don't currently have any of the above symptoms, have you experienced any of these symptoms in the last 14 days? YES____ NO___

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

8. Have you traveled outside the United States by air or cruise ship in the past 14 days? YES ____ NO____

9. Have you traveled within the United States by air, bus or train within the past 14 days? YES ____ NO____

_____ _____

Patient/Guardian Signature Date