COVID-19 QUESTIONNAIRE

Print
Name_______________________________________Date___________Time________

1. Have you recently traveled out of state or country?

   Yes No

2. Have you come in close contact (within 6 feet) with someone who has confirmed COVID-19 diagnosis in the past 14 days?

   Yes No

3. Do you have symptoms of lower respiratory illness such as cough, shortness of breath, difficulty breathing?

   Yes No

4. Do you have a fever (greater than 100.3 or 38.0 C)?

   Yes No

5. Are you experiencing headaches, muscle or body aches, fatigue, sore throat or a new loss of taste or smell?

   Yes No

6. Are you a healthcare worker or first responder?

   Yes No

I attest that I have answered these questions truthfully.

Patient/Guardian Signature_______________________________ Relation____________

In office Temperature Reading________________