**COVID-19 Questionnaire**

*Are you or have you experienced any of these symptoms in the last* ***WEEK****:*

Do you have a fever greater than 100F/38C? YES NO

Do you have a cough? YES NO

Do you have a loss of taste or smell? YES NO

Do you have chills? YES NO

Do you have a sore throat? YES NO

Do you have nasal congestion and/or a runny nose? YES NO

Do you have shortness of breath? YES NO

Do you have a headache? YES NO

Do you have nausea/vomiting or diarrhea? YES NO

Do you have body aches? YES NO

Do you have extreme tiredness or fatigue? YES NO

Have you been exposed to a confirmed diagnosed COVID-19 person? YES NO

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| --- | --- |
| **Patient Signature:** | **Date:** |
| **Patient Printed Name:** | |