Name:	**DOB:**
Prescription Pick-Up / Translator / Driver / Other_____	
If not a patient, provide contact number:	

JAVERY
PAIN INSTITUTE

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

Patient Signature:	**Date:**
Patient Printed Name:	