COVID QUESTIONNAIRE

Patient Name: John Doe **Birth Date:** 5/14/2011

Please answer all questions truthfully regarding your health and symptoms NOW or WITHIN THE LAST 48 HOURS.

Question	Answer
Do you have a fever? (Temperature at or above 100.4 F)	No
Do you have a cough?	No
Are you having shortness of breath or any difficulty breathing?	No
Do you have chills or repeated shaking?	No
Do you have any muscle pain?	No
Do you have a headache?	No
Do you have a sore throat?	No
Do you have any other flu-like symptoms?	No
Do you have any recent loss of taste or smell?	No
Have you experienced any GI issues? Upset stomach? Diarrhea?	No
Are you or have you been in contact with anyone who has been confirmed to be COVID-19 positive?	No

Thank you for taking the time to complete this questionnaire and helping us all to stay safe and healthy. **If you begin feeling any of these symptoms in the next 14 days, please contact our office so that we may monitor our doctors and staff appropriately.** We appreciate your help!

Signature

Date of signing	5/14/2020
Relationship to the patient	Guardian
Name	Jane Roe
IP Address	127.0.0.1

Signature