COVID SYMPTOM QUESTIONNAIRE

Date: ____

Temp: _______________________________________

Patient Name: ____ **D/O/B:** ___________________

Are you feeling sick today? This includes experiencing any NEW symptom(s) listed below that is not due to another health problem: fever or chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headaches, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, diarrhea?

- ○ **Yes**
- ○ **No**

Are you required to self-quarantine for any of the following reasons?

- ○ **No, I am not required to self-quarantine**
- ○ **I have not been fully vaccinated AND have had close contact or household exposure to someone with known or suspected COVID-19 within the last 14 days.**
- ○ **I have tested positive, inconclusive or have test results pending for COVID-19 within the past 14 days.**

Have you received any dose of the COVID-19 vaccine?

- ○ **No, I have not received any dose of the COVID-19 vaccine**
- ○ **I am partially vaccinated**
- ○ **I am fully vaccinated**
- ○ **I am not sure**
- ○ **Decline to answer**

PATIENT SIGNATURE: ____