COVID-19 Patient Questionnaire

To Be Completed Prior to Appointment

1. In the last 48 hours have you had any of the following NEW symptoms? (circle all that apply)

* Fever
* Chills
* Cough
* Sore throat
* Shortness of breath or difficulty breathing
* Runny or stuffy nose
* Muscle aches, body aches, or headache
* New loss of taste or smell
* Fatigue or malaise
* Nausea, vomiting or diarrhea
* None of the above

1. Have you had contact with anyone diagnosed with or suspected of having COVID-19 in the last 14 days?

* Yes
* No

1. Have you travelled recently?

* Yes
* No

If yes, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you have any conditions that put you in a higher risk category? (Circle all that apply)

* Cancer
* HIV
* Taking immunosuppressive medications
* Liver cirrhosis
* Cardiovascular disease (Heart attack, stroke)
* Lung disease (COPD, asthma, lung fibrosis)
* Pregnancy
* High blood pressure
* Diabetes
* None of the above

1. Are you a primary caretaker of someone in a higher risk category?

* Yes
* No

1. Are you a healthcare worker or do you work in a healthcare setting?

* Yes
* No

Patient Name (please print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient or Representative signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_