COVID-19 QUESTIONAIRE

	YES	NO	NOTES
Do you have a fever or have you felt hot and feverish in last 14-21days?			
Are you having shortness of breath or experiencing difficulty breathing?			
Do you have a dry cough?			
Do you have a runny nose?			
Do you have a sore throat?			
Are you experiencing any other flu-like symptoms, such as upset stomach, headache or fatigue?			
Have you experienced recent loss of taste or smell?			
Have you recently been or are you in contact with any confirmed COVID-19 positive patients?			
Have you tested positive for COVID-19?			
Have you been tested for COVID-19 and are awaiting results?			
Have you traveled outside of the united states in the past 14 days?			
Have you traveled within the united states in the past 14 days?			
Have you been around a large group or attend a large gathering/meeting in the past 14 days?			

By signing below, I have answered the above questions truthfully and have not omitted any information. I understand that the information I provide is important in assuring that I am treated safely and to protect those around me. I also understand that in the event that I become positive for COVID-19 or experience any signs or symptoms associated with the COVID-19 virus since my last visit up to 14 days, I will disclose this information to your office so that any exposure to the team can be traced and handled accordingly.
