COVID-19, Cold & Flu Screening Q&A

Pro Natural Health Center LLC 医本堂

(CDC Guideline)

VISIT DATE: _____

Last Name: _____ First Name: _____ Gender: _____

Cell Phone Number: _____

PLEASE READ EACH QUESTION CAREFULLY	**PLEASE CIRCLE THE ANSWER THAT APPLIES TO YOU**	
Have you experienced any of the following symptoms in the past 48 hours: • fever or chills • cough • shortness of breath or difficulty breathing • fatigue • muscle or body aches • headache • new loss of taste or smell • sore throat • congestion or runny nose • nausea or vomiting • diarrhea	**YES** ◯	**NO** ◯
Within the past 14 days, have you been in close physical contact (6 feet or closer for a cumulative total of 15 minutes) with: • Anyone who is known to have laboratory-confirmed COVID-19? OR • Anyone who has any symptoms consistent with COVID-19?	**YES** ◯	**NO** ◯
Are you isolating or quarantining because you may have been exposed to a person with COVID-19 or are worried that you may be sick with COVID-19?	**YES** ◯	**NO** ◯
Are you currently waiting on the results of a COVID-19 test?	**NO** ◯	**NO** ◯