COVID-19 QUESTIONNAIRE

**Patient Name: ­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_D.O.B. \_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please answer the questions below to the best of your knowledge.**

1. **Are you answering for yourself or someone else? \***

**Myself My spouse My child Someone else**

1. **Have you ever tested positive for COVID-19? \***

**YES NO**

1. **Have you been in close contact with another person who has been diagnosed with or under investigation for COVID-19? \***

**Yes No I don’t know**

1. **Have you been fully vaccinated for COVID-19? \***

**YES NO If Yes, what is approximate date of your last shot? ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. **Have you experienced the following symptoms in the last 14 days? \***

**Coughing Fever Shortness of Breath Recent loss of taste or smell**

**Any flu-like symptoms None Other symptoms \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. **In the last two weeks have you worked or volunteered in a hospital, emergency room, clinic, medical office, long-term care facility or nursing home, ambulance service, first responder services, or any health care setting or taken care of patients as a student or part of your work? \***

**Yes No I don’t know**

1. **Have you traveled in the past 14 days to any regions affected by COVID-19? \***

**YES NO**

**X**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of patient** (Parent or Guardian if Minor) **Date**