Island IV, LLC
PO Box 10650
St. Thomas, VI 00801

COVID-19 Questionnaire

Name:_____

Date:_____

Please review and respond to the following questions.

Have you or anyone in your household had any of the following symptoms in the last 21 days: sore throat, cough, chills, body aches for unknown reasons, shortness of breath for unknown reasons, loss of smell, loss of taste, fever at or greater than 100 degrees Fahrenheit?

_____

Have you or anyone in your household been tested for COVID-19? _____

What was the result? _____

Have you or anyone in your household visited or received treatment in a hospital, nursing home, long-term care, or other health care facility in the past 30 days?

_____

Have you or anyone in your household traveled in the U.S. in the past 21 days? _____

Have you or anyone in your household traveled on a cruise ship in the last 21 days?_____

Are you or anyone in your household a health care provider or emergency responder? _____

Have you or anyone in your household cared for an individual who is in quarantine or is a presumptive positive or has tested positive for COVID-19?

_____

Do you have any reason to believe you or anyone in your household has been exposed to or acquired COVID-19?

_____

To the best of your knowledge have you been in close proximity to any individual who tested positive for COVID-19?

_____

If you have answered "Yes" to any questions, please contact us prior to your appointment.