CORONAVIRUS QUESTIONNAIRE

Please complete and either bring to the office, if received electronically, or hand to the front desk when finished.

1). Have you traveled to any of these locations in the last 14 days?

☐ **Yes** ☐ **No**

Check all that apply:

☐ China ☐ South Korea ☐ Italy ☐ Japan

☐ New York/New Jersey ☐ Other _____

2). Have you been on a Cruise since Feb 2020? ☐ **Yes** ☐ **No**

If Yes, Which Cruise Line/Ship? _____

Where did it go? _____

3). **Have you come into close contact (within 6 ft) with anyone with a laboratory confirmed COVID-19 in the last 14 days?** ☐ **Yes** ☐ **No**

4). **Have you had any of these symptoms in the last 14 days?**

☐ Fever greater than 100 ☐ Difficulty breathing/Shortness of Breathe

☐ Cough ☐ Chills ☐ Muscle Pain ☐ Headache

☐ Sore Throat ☐ Loss of Taste

If you answered No to question 1 and/or 2, but Yes to 3 & 4, please let our office know and call your primary care provider.

Please adhere to the social distancing and do not get close to anyone with a compromised immune system or other underlying condition.

For a TRUE MEDICAL EMERGENCY, call 911 or go to your closest Emergency Room

Patient Name: _____

Temperature at time of visit: _____ Date of Visit: _____