PATIENT QUESTIONNAIRE

Have you been diagnosed with COVID-19 or have you been in contact with someone who has known or suspected COVID-19 in the last 21 days?

YES NO

Do you have a fever, cough, shortness of breath, chills, muscle pain, headache, sore throat, or loss of taste or smell?

YES NO

Is anyone in your home on home “self-monitoring” or “home isolation”?

YES NO

Do you have a face mask? (All patients are required to wear a face mask).

YES NO

If we have and supply a mask, there is a charge of $3 to $5 depending on the type mask dispensed.

NAME_____

SIGNATURE_____

DATE_____