CORONAVIRUS/ COVID-19 PATIENT QUESTIONNAIRE

[SEVERE ACUTE RESPIRATORY SYNDROME CORONAVIRUS 2 (SARS-CoV-2)]

Patient Information:

____________________________	______________________	_____________
Last Name	**First Name**	**Date**

1. Do you have a fever? ☐ Yes or ☐ No
   If Yes, please explain: ____
2. Do you have chills? ☐ Yes or ☐ No
   If Yes, please explain: ____
3. Do you have shortness of breath? ☐ Yes or ☐ No
   If Yes, please explain: ____
4. Do you have a cough? ☐ Yes or ☐ No
   If Yes, please explain: ____
5. Do you have fatigue unrelated to a sleep issue? ☐ Yes or ☐ No
   If Yes, please explain: ____
6. Have you been exposed to anyone with the Coronavirus / Covid-19? ☐ Yes or ☐ No
   If Yes, please explain: ____
7. Have you travelled within the last 2-3 weeks? ☐ Yes or ☐ No
   If Yes, please explain: ____
8. Have you been in close proximity or intimate contact with anyone who has traveled out of the country within the last 2-3 weeks, especially to Italy, China, or another heavily infected country? ☐ Yes or ☐ No
   If Yes, please explain: ____
9. Are you immunocompromised? ☐ Yes or ☐ No
   If Yes, please explain: ____
10. Do you have an auto-immune disorder / condition? ☐ Yes or ☐ No
    If Yes, please explain: ____
11. Are you on any chemotherapeutic agents? ☐ Yes or ☐ No
    If Yes, please explain: ____
12. Do you have any recent loss of smell or taste? ☐ Yes or ☐ No
    If Yes, please explain: ____
13. Have you recently been tested for COVID-19? ☐ Yes or ☐ No
    If Yes, please indicate your test result (positive / negative): ____________________

____________________________	____________________________	___________	___________
Signature	Printed Name	Date	Time