CORONAVIRUS/ COVID-19 PATIENT QUESTIONNAIRE

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

Patient Information:

_____ _____ _____

Last Name **First Name** **Date**

1. Have you received the Covid-19 Vaccine? Yes or No
    a. If Yes, when was your first shot? _____
    b. If Yes, when was your second shot? _____

If you have received the SECONDD vaccination over 4 weeks ago, then you do not need to fill out the rest of this questionnaire but please so sign/date this form.

2. Do you have a fever? Yes or No
3. Do you have chills? Yes or No
4. Do you have shortness of breath? Yes or No
5. Do you have a cough? Yes or No
6. Do you have fatigue unrelated to sleep issue? Yes or No
7. Have you been exposed to anyone with the Coronavirus? Yes or No
8. Have you been traveling within the last 2-3 weeks? Yes or No
9. Have you been in proximity or intimate with anyone who has traveled out of the country within the last 2-3 weeks, especially Italy, China, or other highly infected countries? Yes or No
10. Are you immunocompromised? Yes or No
11. Do you have an auto-immune condition? Yes or No
12. Are you on any chemotherapeutic agents? Yes or No
13. Do you have any recent loss of smell or taste? Yes or No (If Yes, which one? _____
14. Have you recently been tested for COVID-19? Yes or No

    If Yes: Result: Positive Negative

    _____ _____ _____ _____

    Signature Name Date Time

15. If you filled out this form before this date, please sign/date if there are no changes.

    _____ _____ _____ _____

    Signature Name Date Time