COVID-19 QUESTIONNAIRE

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We appreciate your cooperation and patience in helping to keep our office staff and patients safe and healthy.

Patient's Name: _____ **Today's Date:** _____

Have you travelled outside of the U.S. in the past 30 days? **YES** **NO**
If yes, where? _____

Have you travelled to a U.S. City/State with reported cases of Covid-19 in the past 30 days? **YES** **NO**
If yes, where? _____

Have you been in personal contact with a person infected with Covid-19 or who has travelled to an area with widespread and ongoing transmissions of Covid-19 in the past 30 days? **YES** **NO**

IN THE LAST 48 HOURS:

Have you had a fever (99.5+)? **YES** **NO**

Have you experienced any of the following:

Coughing? **YES** **NO**

Sore Throat? **YES** **NO**

Difficulty Breathing? **YES** **NO**

Muscle Aches? **YES** **NO**

Stomach Pain? **YES** **NO**

COVID VACCINATION RECORD:

Have you received a partial or complete vaccination for Covid-19? **YES** **NO**

If yes, please provide copy of your vaccination card for verification and to be scanned into your patient chart. Thank you

Patient Signature: _____Date: _____