COVID Questionnaire

1. Do you or anyone you live with have any of the following symptoms today? (Please circle all that apply).

Fever

Cough

Shortness of breath

Chills

Repeated shaking with chills

Muscle pain

Headache

Sore throat

New loss of taste or smell

New GI symptoms

Other respiratory problems

NONE

2. Temperature: _____. *If a fever above 100.0 F, the procedure will be rescheduled.

3. Have you or anyone you live with been exposed to the virus or tested positive in the past 14 days? YES NO

4. Have you traveled in the past 14 days? Domestically and/or internationally.

YES NO

If yes, explain:

_____

*International travel will require the patient to quarantine. Please contact your primary physician for details.

For more information on COVID-19, please visit the **CDC website.**