COVID-19 Specific Patient History Questions

- Have you tested positive for COVID-19 in the last 14 days? Y/N
- Do you currently have symptoms of fever, new onset or worsening of chronic cough, difficulty breathing, sore throat or new loss of taste or smell? Y/N
- Have you had close contact with someone who is confirmed as having COVID-19 in the past 14 days? Y/N
- Within the past 14 days, have you arrived from another country or traveled outside the immediate area and stayed for more than 24 hours? Y/N
- Are you a member of a high-risk population for contracting COVID-19? Y/N

Patient Name ____

Signature ____

Date __________________________