Patient Name: _____ Temp: _____

Date of Birth: _____

Yes	No	
		Have you or anyone in your household had any of the following symptoms in the last 21 days: sore throat, cough, chills, body aches for unknown reasons, shortness of breath for unknown reasons, loss of smell, loss of taste, fever at or greater than 100 degrees Fahrenheit?
		Have you or anyone in your household been tested for COVID-19?
		Have you or anyone in your household visited or received treatment in a hospital, nursing home, long-term care, or other health care facility in the past 30 days?
		Have you or anyone in your household traveled in the U.S. in the past 21 days?
		Have you or anyone in your household traveled on a cruise ship in the last 21 days?
		Have you or anyone in your household cared for an individual who is in quarantine or is a presumptive positive or has tested positive for COVID-19?
		Do you have any reason to believe you or anyone in your household has been exposed to or acquired COVID-19?
		To the best of your knowledge have you been in close proximity to any individual who tested positive for COVID-19?
		I have a mask
		I need a mask (5$)

Signature: _____

Date: _____