TRAVEL and SYMPTOM QUESTIONAIRE for Check in and MA

Have **YOU** traveled anywhere in the last 14 days? Yes No

If yes, WHERE? _____

Any airport/layovers? Give the airport name: _____

Are you under a quarantine? Yes No

Do you have a fever? Yes No

Do you have shortness of breath? Yes No

Do you member have a cough? Yes No

Do you have chills? Yes No

Do you have repeated shaking with chills? Yes No

Do you have muscle pain? Yes No

Do you have a headache? Yes No

Do you have a sore throat? Yes No

Do you have a new loss of taste or smell? Yes No

Have you been tested for COVID-19? Yes No

If Yes, what was the result? _____ If Yes, are the results still pending? _____

Have **YOU** had close contact with a person known to have COVID-19 illness? Yes No

Are **YOU** caring for someone with a known Coronavirus (COVID-19) illness? Yes No

Has anyone in your **HOUSEHOLD** traveled anywhere in the last 14 days? Yes No

Are they under a quarantine? Yes No

Are they under a home isolation? Yes No

Do they have a fever? Yes No

Do they have shortness of breath? Yes No

Do they have a cough? Yes No

Have they been tested for COVID-19? Yes No

If Yes, what was the result? _____ If Yes, are the results still pending? _____

Patient Name: _____ Today's Date: _____

Patient's Date of Birth: _____