

First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you experienced any of the following symptoms in the last 7 days?

Had a fever? Yes No

Cough or sore throat? Yes No

Shortness of breath / Difficulty breathing? Yes No

Recent loss of taste or smell? Yes No

Other flu like symptoms (gastrointestinal upset, headache, or fatigue) Yes No

Have you or anyone who you have come into contact with tested positive for COVID19 in the last 7 days?

Yes No

If yes: Have you been vaccinated for COVID19?

Yes No

Are you living in the same household as the individual who has tested positive in the last 7 days?

 Yes No

If you answered yes to any of the above questions, please explain:

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_