COVID-19 Questionnaire

Name: ___________________________

Date: ____________________________

Temperature: _____________________

O_2 Saturation: ____________________

1. Have you had any of the symptoms of COVID-19, including fever, headaches, cough, shortness of breath, and loss of smell and taste? Please Circle: Yes No

   If yes, how long did symptoms last? _____________

   How long have symptoms been absent? ____________

2. Have you been around any individual who has had these symptoms or tested positive for Covid? Please Circle: Yes No
   If yes, how long has it been since you have been in contact with them? ______________

3. Do you live in an assisted living facility or a Nursing Home? Please Circle: Yes No

4. Have you had the COVID virus? Please Circle: Yes No

   If yes, were you hospitalized? Please Circle: Yes No
   Release date__________ Last test date ________ (Please Circle: Positive / Negative)