Covid-19 Symptom Questionnaire

1. Have you been within 6 feet of a person with a lab-confirmed case of COVID-19 for at least 15 minutes, or had direct contact with their saliva or mucus in the past 14 days?

YES NO

1. Do you have any of the following symptoms? Please check all that apply:

 Fever of 100.4 and above or fever-like symptoms, such as, alternating chills and sweating.

 Cough

 Trouble breathing, shortness of breath, or wheezing

 Chills or repeated shaking with chills

 Muscle aches

 Sore throat

 Loss of smell or taste, or a change in taste

 Nausea, vomiting, or diarrhea

 Headache

 None of the above

If you answered yes to any of the above questions or symptoms, please do not attend practice and consult with your health care provider.