Today's Date: _____ Name and Date of Birth: _____

Do you have a fever or have you felt hot or feverish within the last 14 days?	Yes / No
Are you having shortness of breath or other difficulties breathing?	Yes / No
Do you have a cough?	Yes / No
Do you have any other flu-like symptoms, such as gastrointestinal upset, headache, or fatigue?	Yes / No
Have you experience a recent loss of taste or smell?	Yes / No
Are you in contact with or caring for any confirmed COVID-19 positive patients?	Yes / No
Do you have heart disease, lung disease, kidney disease, diabetes, or any auto-immune disorders?	Yes / No
Have you traveled in the past 14 days to any regions affected by COVID-19?	Yes / No

Signature _____

Office Use Only: temperature_____