Date:_________________ **PATIENT NAME:_______________________________**
Workplace:______________ **DOB:____**
CONTACT #:__________________________________

Do you have any of the following symptoms?

- ☐ Cough
- ☐ Shortness of breath or difficulty breathing
- ☐ Fever
- ☐ Chills
- ☐ Unexplained Muscle pain or body aches
- ☐ Headache
- ☐ Sore throat
- ☐ New loss of taste or smell
- ☐ Diarrhea or Vomiting
- ☐ Congestion or Runny nose
- ☐ Fatigue
- ☐ Nausea

Symptom Onset: ____

Have you had contact with a person diagnosed with COVID-19? YES / NO

Name of positive contact: ____

Date of last contact: ____

Physical Address & Household Members:

____
____
____

Fully Vaccinated?

Yes______ NO______