Patient name:_____ DOB:_____

COVID-19 Questionnaire

Check your temperature the morning of your appointment.
If temperature <100.4 F → go to your appointment
If temperature >100.4 F → stay home and call the office, 972-347-9617

1. Have you tested positive for COVID-19?
   - Yes
   - No

2. Have you been tested for COVID-19 and are awaiting results?
   - Yes
   - No

3. Do you have any of the following respiratory symptoms? Fever, Sore Throat, Cough, Shortness of Breath?
   - Yes
   - No

4. Have you recently lost your sense of smell or taste?
   - Yes
   - No

5. Do you have any GI symptoms? Diarrhea? Nausea?
   - Yes
   - No

6. Even if you don't currently have any of the above symptoms, have you experienced any of these symptoms in the last 14 days?
   - Yes
   - No

7. Have you been in contact with someone who has tested positive for COVID-19 in the last 14 days?
   - Yes
   - No

8. Have you traveled outside the United States by air or cruise ship in the past 14 days?
   - Yes
   - No

9. Have you traveled within the United States by air, bus or train within the past 14 days?
   - Yes
   - No

_____ _____
Signature Date