Spectrum DERMATOLOGY

COVID QUESTIONNAIRE

1. Have you received the COVID-19 vaccine?

☐ No

☐ Yes, 1 dose (please provide type and date): _____

☐ Yes, 2 doses (please provide type and dates): _____

2. Do you have a fever?

☐ Yes ☐ No

3. Do you have any of the following signs or symptoms?

☐ New onset of cough ☐ Worsening chronic cough ☐ Sore throat ☐ Shortness of breath

☐ Difficulty breathing ☐ New loss or decrease in sense of taste or smell ☐ Runny nose ☐ Chills

☐ Headache ☐ Unexplained fatigue or malaise ☐ Difficulty swallowing

☐ Nausea/vomiting, diarrhea, abdominal pain ☐ No symptoms

4. Have you travelled or have had close contact with anyone who has travelled internationally in the past 14 days?

☐ Yes ☐ No

5. Have you had close contact with anyone with respiratory illness or a confirmed or probable/suspected case of COVID-19?

☐ Yes ☐ No

If you have answered "yes" to questions 2, 4, or have checked off signs or symptoms, you may need to reschedule your appointment. Please call the office to determine if you need to reschedule.

_____

Patient Name

_____ _____

Patient or Guardian Signature Date

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