CORONAVIRUS/COVID-19 PATIENT SAFETY QUESTIONNAIRE

Name:_____ Date_____

1. **Have you traveled outside the United Sates or any regions affected by COVID-19 (as relevant to your region) in the past 10 days?**

   _____ Yes _____No

2. **Have you experienced any of the following symptoms in the past 48 hours:**

   Fever or chills; cough; shortness of breath or difficulty breathing; fatigue; muscle or body aches; headache; new loss of taste or smell; sore throat; congestion or runny nose; nausea or vomiting; diarrhea.

   _____ Yes _____No

3. **Have you been in close physical or unprotected contact in the last 14 days with:**

   Anyone who is known to have laboratory-confirmed COVID-19? Or, anyone who has any symptoms consistent with COVID-19?

   _____ Yes _____No

4. **Are you isolating or quarantining because you may have been exposed to a person with COVID-19 or are worried that you may be sick with COVID-19?**

   _____ Yes _____No

5. **Have you been tested for COVID-19 in the last 14 days?**

   _____ Yes _____No

   If Yes, what is the result? _____Negative _____Positive

6. **Are you currently waiting on the results of a COVID-19 test?**

   _____ Yes _____No

Thank you for your cooperation and understanding during the coronavirus pandemic. We respect your concerns and understand your need to be seen for diagnosis and treatment.

Signature_____