Respiratory Illness Signs & Symptoms Questionnaire for Patient

Please answer YES or NO to the following questions:

Have you recently felt feverish? Current or recent fever greater than 100.4F (38 C). YES NO

Do you have a cough (not related to allergy)? YES NO

Are you experiencing shortness of breath, trouble breathing, persistent headache, severe fatigue, or loss of taste and smell? YES NO

Have you or anyone you live with been in close contact with any person who may be sick with a flu-like illness or Coronavirus (COVID-19)?

YES NO

Have you or anyone you live with traveled to another state in the US in the past 30 days? YES NO

If yes: Name of State and when:

Have you or anyone you live with traveled outside of the US in the past 30 days? YES NO

If yes, Name of Country and when:

Name: _____

Signature: _____

Today's date: _____

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