Covid Pre-Treatment Questionnaire

Name ______________ Date__________

Have you had contact with a covid positive patient?	Y / N
Have you had recent loss of taste/smell?	Y / N
Do you have flu like symptoms, including: -GI upset -Headache -Fatigue	Y / N
Do you have a cough?	Y / N
Do you have shortness of breath or difficulty breathing?	Y / N
Have you had a recent fever? (within past 2 weeks)	Y / N
Have you traveled within the past 14 days	Y / N