# HEALTH QUESTIONNAIRE

1. Do you currently have a fever or symptoms of a respiratory infection, such as a cough, sore throat, or shortness of breath?

   YES _____ NO _____

2. Have you recently experienced a loss of taste or smell?

   YES _____ NO _____

3. Have you had any contact with someone with known, suspected COVID-19/Coronavirus OR with an immediate family member who has exhibited signs and symptoms of fever and/or respiratory infection such as a cough, sore throat, or shortness of breath?

   YES _____ NO _____

_____ Date: _____
Patient signature

_____
Patient printed name