COVID-19 QUESTIONNAIRE

Indicate if in the last 48 hours you have presented any of the following symptoms

Fever	YES	NO
Sore throat	YES	NO
Headache	YES	NO
Cough	YES	NO
Complications Breathing	YES	NO
Chest Pain	YES	NO
Flu	YES	NO
Runny Nose	YES	NO
Chills	YES	NO

Have you been in vcontact6 with a patient diagnosed with COVID-19 in the last 15 days? YES NO

Have you travel to another country in the 30 day YES NO

Client Signature: _____ Date:_____