WELLNESS FORM

Name: _____ Phone: _____

E-Mail: _____

Signature: _____ Date: _____

Do you have a cough? Yes _____No _____

Do you have a fever now or have you in the past 14-21 days? Yes _____ No _____

Have you come in contact with any confirmed COVID-19 positive patients in the last 14 days? Yes _____ No _____

Are you experiencing difficulty breathing, flu like symptoms, headache, sore throat or fatigue? Yes _____ No _____

Have you experienced recent loss of taste or smell? Yes _____ No _____

Have you traveled in the past 14 days to any regions affected by COVID-19? (as relevant to your location) Yes _____ No _____