COVID-19 Questionnaire

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Dublin CA, 94568
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Email: ironhorsevetcare@gmail.com

Date/Time:

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First & Last Name: ____________________________________

Patient Name: ______________________________________

Have you experienced any of the following symptoms in the past 48 hours:

- Fever or chills
- cough
- shortness of breath or difficulty breathing
- fatigue
- muscle or body aches
- headache
- new loss of taste or smell
- sore throat
- congestion or runny nose
- nausea or vomiting
- diarrhea

☐ Yes ☐ No

Within the past 14 days, have you been in contact with a person who is known to have tested positive for COVID-19 or has any symptoms consistent with COVID-19?

☐ Yes ☐ No

Are you isolating or quarantining because you may have been exposed to a person with COVID-19 or are worried that you may be sick with COVID-19?

☐ Yes ☐ No

Are you currently waiting on the results of a COVID-19 test?

☐ Yes ☐ No

Signature:

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