Recent Health History

1.) Do you have any symptoms of a respiratory infection (cough, sore throat, congestions, shortness of breath) now or within the past week? Yes No

2.) Do you have any symptoms of the stomach flu (nausea, vomiting, diarrhea) now or within the past week? Yes No

3.) Have you had a fever or repeated temperatures over 99.5 degrees or any associated muscle aches/pain over the past week? Yes No

4.) Have you been in contact with family members or people who are sick with a fever or respiratory infection? Yes No

5.) Have you had confirmed or suspected contact with any individual diagnosed with COVID-19 within the last 14 days? Yes No

6.) Have you continued to work in/at an essential business during the last 30 days? Yes No

7.) Have you practiced adequate social distancing in recent weeks? Yes No

8.) Have you home quarantined for any extended period prior to this visit? Yes No

9.) Have you used personal protective equipment when leaving your home? Yes No

10.) Have you received a COVID-19 vaccine? Yes No

a. If so, single dose or double dose? _____

Name:_____

Signature:_____

Date:_____