Patient name____

Appointment date/time___________________________________

In the last 14 days, have you experienced any of the following symptoms: (circle your answer)

1. Fever > 99.5 degrees Fahrenheit YES or NO
2. Cough YES or NO
3. Shortness of breath YES or NO
4. Diarrhea YES or NO
5. Loss of smell or taste sense YES or NO
6. Do you currently have a physician order for a COVID-19 test? YES or NO
7. Have you, at any time in the past, tested positive for COVID-19? YES or NO
   a. If so, when? _______________________________
8. Have you been exposed to a person with COVID-19 in the last 7 days? YES or NO
9. Have you traveled outside of Pennsylvania in the last 10 days?
   a. If so, where? _____________________________________
10. Have you been vaccinated against COVID-19? YES or NO
    a. If yes, please give dates received ____________________
    b. If no, do you intend to get vaccinates? YES or NO
11. Have you received an influenza vaccine ("the flu shot") between 8/1/21 and 3/31/22? YES or NO

Signature____