# WELLNESS FORM

Print First Name_____ Print Last Name_____

Do you have a cough?

Yes___ No__

Do you have a fever now or in the last 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 shortness of breath or difficulty breathing?

Yes___ No___

Are you experiencing any other flu-like symptoms, such as gastrointestinal upset, headache, or fatigue?

Yes___ No__

Have you experienced resent loss of taste or smell?

Yes___ No__

Are you over the age of 60?

Yes___ No__

Do you have heart disease, lung disease, kidney disease, diabetes, or any auto-immune disorders?

Yes___ No__

Have you traveled in the past 14 days to any regions affected by COVID 19 (as relevant to your location)?

Yes___ No__

Signature: _____ Date: _____

OFFICE USE ONLY:

Temp: _____