Wellness Form

First Name

Last Name

Phone

Email

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 shortness of breath or difficulty breathing?

Yes No

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

Yes No

Have you experienced recent 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, or diabetes or any auto-immune disorders?

Yes No

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

Yes No

Signature

Date