Patient Name: _____

Patient Date of Birth:_____

Patient Height:_____ Patient Weight:_____

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URGENT COVID Questionnaire: Your Symptoms

1. When did you first start having symptoms? Date: _____
2. When did you have a positive test? Date: _____
3. **Check the box** for any/all your symptoms below:

	PAST	PRESENT
a. Fever, if so, how high has your temperature been?	☐	☐
i. Highest temperature: _____		
b. Chills	☐	☐
c. Muscle or body aches	☐	☐
d. Fatigue	☐	☐
e. Sore throat	☐	☐
f. Headaches	☐	☐
g. Sinus/nasal congestion or runny nose	☐	☐
h. Cough – productive (circle one)?	☐	☐
➔ If cough still present, what color phlegm/sputum_____		
i. Shortness of breath or difficulty breathing	☐	☐
j. Wheezing	☐	☐
k. Nausea/vomiting	☐	☐
l. Diarrhea	☐	☐
m. New loss of taste or smell	☐	☐

4. Are you checking oxygen levels with oximeter? YES NO
   - ➔ If not, buy one ASAP and start checking. If YES, list the range of your oxygen levels, if it dropped, when it dropped, etc.
   - ➔ _____
6. Have you previously had COVID-19? ☐ Yes ☐ No Date: _____
7. Have you received any COVID-19 vaccinations? ☐ Yes ☐ No Date(s): _____

➔If so, which ones? _____

8. Other concerns:

_____

_____