# COVID-19 RISK ASSESSMENT QUESTIONNAIRE

1. Have you experienced any of the following symptoms within the past 14 days? Please select all that apply.

   - Fever, chills, or sweating
   - New or worsening cough
   - Fatigue
   - Body aches
   - Diarrhea
   - Reduced sense of smell and/or taste
   - Difficulty breathing
   - None of the above

2. To your knowledge, is it possible you may have been exposed to COVID-19 within the past 14 days?

   - Yes
   - No

3. Have you been tested before for COVID-19?

   - Yes, results negative
   - Yes, results positive
   - No

Patient Name Printed: ______________________________________________

Patient Name Signature: ____________________________________________

Date: ___________________________________________________________