COVID-19 Patient Questionnaire

Please answer the following questions prior to your visit today. If you answer yes to any of the following questions, please do not proceed with your visit. We will reschedule your appointment. Thank you for your help in ensuring the health and safety of our staff and patients!

In the last two weeks, have you…

…had a fever ≥100 F?	☐ Yes ☐ No
…had a cough, runny nose, sore throat?	☐ Yes ☐ No
…felt lethargic or fatigued?	☐ Yes ☐ No
…experienced a loss of taste or smell?	☐ Yes ☐ No
…had any vomiting, diarrhea or other GI symptoms?	☐ Yes ☐ No
…been exposed to anyone with the above symptoms?	☐ Yes ☐ No
…been exposed to anyone currently positive for COVID?	☐ Yes ☐ No
…travelled out of the state?	☐ Yes ☐ No
…been in contact with anyone that has recently been out of the country?	☐ Yes ☐ No

Have you tested positive for COVID <u>at any time</u> since March 2020? ☐ Yes, (when) _____ ☐ No

Have you been vaccinated? ☐ No ☐ Yes, received 1st dose on (date) _____
☐ Yes, received 2nd dose on (date) _____
☐ Yes, received booster on (date) _____

By signing below, I certify that the answers to this questionnaire are accurate and true. I have had no symptoms or known exposure to the COVID-19 virus.

_____	_____	____/____/____
Print Name	Sign Name	Date
_____	_____	____/____/____
Print Name	Sign Name	Date

For KCS staff use only:

Above signed by: □ Patient/Study Partner □ Clinical (non-study) □ Visitor

□ Patient/study partner/visitor, if applicable, denied all of the above and confirmed they have had no known symptoms or exposure to the COVID-19 virus

□ Patient/caregiver/visitor, if applicable, had a body temperature below 100F

_____	____/____/____
Signature of KCS staff member	Date