COVID-19 Pandemic Period Patient Questionnaire

- Have you had any of the symptoms of COVID-19 that may include:
    - Fever
    - Headache
    - Cough
    - Shortness of breath
    - Headache
    - Muscle ache
    - Chills or shaking with chills
    - Loss of smell or taste
- Have you been around any individual who has had these symptoms or tested positive for COVID-19? If so, how long has it been since you have been in contact with them?
- Have you been practicing social distancing?
- Have you been at home following the stay at home guidelines?
- Have you visited an assisted living home, nursing home, hospital or any area that is treating COVID-19 patients?
- Have you had the COVID-19 virus?

Other Questions

1) What is the nature of your pain?
2) How long has the area been painful?
3) On a scale of 1-10, quantify your pain or discomfort?
4) Are you swollen or do you feel any swelling?
5) What are your current medical alerts or conditions?
6) Do you have a history of respiratory problems?
7) What medications are you taking?
8) Have you taken medication for the emergency you are calling for?
9) What are your known allergies?
10) Do you have allergies to any medications?
11) Have you also filled out our standard health history? If not, please complete it now.