ABDOMINAL SPECIALISTS OF SOUTH TEXAS, LLP

COVID 19 QUESTIONNARIE

(ONLY FOR COVID SYMPTOMS)

1) Have you had testing for Covid 19 in the past 14 days? ☐ Yes ☐ No

    1. If **YES,** date? _____
    2. Results: ☐ Positive ☐ Negative

2) Do you have any of the following?

    a) Fever 100.4 degrees or higher within the past 3 days? ☐ Yes ☐ No

    b) Cough? ☐ Yes ☐ No

    c) Shortness of breath, difficulty breathing, or chest pain? ☐ Yes ☐ No

    d) Sore throat? ☐ Yes ☐ No

    e) Lack of sense of smell? ☐ Yes ☐ No

    f) Lack of sense of taste? ☐ Yes ☐ No

    g) New onset of fatigue or lack or energy? ☐ Yes ☐ No

    h) Nausea with or without vomiting? ☐ Yes ☐ No

    i) Diarrhea? ☐ Yes ☐ No

3) Have you recently traveled (within the past 14 days)? ☐ Yes ☐ No

4) In the past 14 days, have you come into contact
(Within 6 feet) of someone with lab confirmed Covid 19 diagnosis? ☐ Yes ☐ No

5) Are you a first responder, healthcare worker? ☐ Yes ☐ No

6) Do you work or volunteer at a hospital or healthcare facility? ☐ Yes ☐ No

7) Are you an employee or a daycare facility, senior living, adult day-
Care, extended care or rehabilitation care facility? ☐ Yes ☐ No

8) Have you had Covid Vaccinations? ☐ Yes ☐ No

#1 Date: _____ #2 Date: _____

Booster: _____

Which Vaccine: ☐ Pfizer ☐ Moderna ☐ Johnson & Johnson

Any symptom question answered **YES (2a-2i)** should result in a referral to the PCP for assessment and possible testing.