montgomery medical associates, pc

Modern Medicine | Old-Fashioned Care

COVID19 Patient Questionnaire

UPDATED: 10/7/2020

Please circle the Yes or No to each question below

1. Have you traveled outside the state of Maryland recently (within the last 14 days)? Yes or No

2. Have you traveled outside the country within the last 3 months? Yes or No

3. Have you come into contact with anyone who has an Upper Respiratory Infection ***(cough, congestion, nasal drip and/or stuffiness, sneezing, fever, fatigue, headache, inflammation of lymph nodes, sore throat, vomiting or nausea)*** or tested positive for the COVID19 virus? Yes or No

4. Have you been tested for COVID19 virus? Yes or No

    a. If Yes, what was the result and date of result? _____

5. Are you experiencing the following symptoms?
    - **Fever (101*F) YES or NO**
    - **Cough YES or NO**
    - **Shortness of breath YES or NO**
    - **Upper Respiratory Infection Symptoms *(cough, congestion, nasal drip and/or stuffiness, sneezing, fever, fatigue, headache, inflammation of lymph nodes, sore throat, vomiting or nausea)***

Patient Name: _____

Date of Birth: _____

Date:_____