

Covid-19 Questionnaire

1. Have you had a fever in the last 14 days? Yes_____ No_____
2. Have you lost taste or smell in the last 30 days? Yes_____ No_____
3. Have you experienced respiratory problems such as cough or difficulty breathing in the last 14 days Yes_____ No_____
4. Have you been in contact with any person(s) with confirmed covid-19 or flu-like symptoms in the last 14 days? Yes_____ No_____
5. Have you recently participated in any professional or social gatherings where you may have had close contact with many unacquainted people? Yes_____ No_____