COVID-19 Information (OPTIONAL)

Are you experiencing symptoms consistent with COVID-19 (fever, cough, shortness of breath)?

Yes ___ No ___

When did your symptoms begin? Date: ______________

When did you begin your isolation? Date: ______________

When did you begin your quarantine? Date: ______________

If hospitalized, what date were you admitted to the hospital? Date: ______________

If known, what is the COVID-19 test result or confirmed disease status? Date: ______________

If tested for COVID-19, when were you tested? Date: ______________

If tested for COVID-19, what date were the test results provided to you? Date: ______________

What is your current symptomatic disposition?

Currently symptomatic ___ No Longer symptomatic ___ Confirmed recovery___ Deceased ___

What is the date of your current symptomatic disposition? Date: ______________

Clinical Health Notes:

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