If you are feeling ill or have a known exposure to COVID-19, please complete this document and give to your provider.

1. Does anyone in your household currently have any of these symptoms? (check all that apply):

\_\_\_\_\_Fever or chills

\_\_\_\_\_Cough

\_\_\_\_\_Shortness of breath or difficulty breathing

\_\_\_\_\_Fatigue

\_\_\_\_\_Muscle or body aches

\_\_\_\_\_Headache

\_\_\_\_\_Recent loss of taste or smell

\_\_\_\_\_Sore throat

\_\_\_\_\_Congestion

\_\_\_\_\_Nausea or vomiting

\_\_\_\_\_Diarrhea

\_\_\_\_\_Explanation for any checked above:

1. Has anyone in your household been exposed to someone with a suspected and/or confirmed case of the Coronavirus/COVID-19? Has anyone been told to self-isolate or quarantine?

\_\_\_\_\_Yes

\_\_\_\_\_No

\_\_\_\_\_If yes, please explain:

1. Has anyone in your household had a positive COVID-19 test for active virus in the past 10 days, or are you awaiting results of a COVID-19 test?

\_\_\_\_\_Yes

\_\_\_\_\_No

\_\_\_\_\_If yes, please explain:

1. Has anyone in your household traveled internationally within the last 14 days?

\_\_\_\_\_Yes

\_\_\_\_\_No

\_\_\_\_\_If yes, please explain:

1. Have you made a decision about vaccination? If so, who is vaccinated in your household? (Fully vaccinated households may not be required to wear masks in the office).

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