**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you had a positive COVID-19 test for active virus in the past 10 days YES NO**

**Within the past 14 days, have you had contact with anyone that you know had COVID-19 or COVID-like symptoms? Contact is being 6 feet (2 meters) or closer for more than 15 minutes with a person, or having direct contact with fluids from a person with COVID-19 (for example, being coughed or sneezed on) YES NO**

**Have you been asked to self-quarantine or self-monitor because of Concerns of COVID? YES NO**

**Please circle the following conditions or symptoms that you are currently experiencing. Check here if none:\_\_\_\_\_\_\_\_**

GENERAL: weight loss weight gain fatigue difficulty sleeping

 stress fevers chills night sweats

difficulty swallowing difficulty speaking sore throat body aches

Neurologic: Headaches Pain in neck area weakness of arms or legs seizures

Loss of vision back pain Loss of muscle bulk head trauma

Blurred vision joint pain cramping of muscles Memory loss

Double vision muscle pain twitching of muscles loss of hearing

Dizziness Numbness of arms or legs loss of consciousness tingling sensation

Balance trouble Difficulty with coordination Difficulty walking Facial Pain

Poor concentration Weakness of facial muscles Loss of taste Ringing in ears

Difficulty swallowing Difficulty finding right words Loss of smell Change in personality

Difficulty controlling bladder Difficulty controlling bowels Problems pronouncing words

CARDIOVASCULAR: palpitations chest pain

RESPIRATORY: shortness of breath sleep apnea

GASTROINTESTINAL: reflux/indigestion constipation diarrhea

URINARY: increased frequency hesitancy urgency incontinence

urinary infections

MUSCULOSKELETAL: joint pain bone pain arthritis back pain

neck pain muscle pain

DERMATOLOGICAL: rashes oral ulcers shingles

HEMATOLOGICAL: bruising bleeding blood clots

PSYCHIATRIC: depression anxiety