COLORADO
EYE CONSULTANTS

COVID PATIENT QUESTIONAIRE

In an effort to ensure the safety of our patients, staff and providers we ask that you please fill out the following questionnaire.

1. Do you have any of these symptoms that are not caused by another condition?
   a. Fever or chills □
   b. Cough □
   c. Shortness of breath or difficulty breathing □
   d. Fatigue □
   e. Muscle or body aches □
   f. Headache □
   g. Recent loss of taste or smell □
   h. Sore throat □
   i. Congestion □
   j. Nausea or vomiting □
   k. Diarrhea □

2. Have you had a positive COVID-19 test for active virus in the past 5 days?
   □ **YES** □ **NO**

3. Within the past 5 days, has a public health or medical professional told you to self-monitor, self-isolate, or self-quarantine because of concerns about COVID-19 infection?
   □ **YES** □ **NO**

Patient Name	**Chart #**	
Patient Signature	**Date**	**Time**
Signature of Legal Patient Representative: ***(If patient is unable to sign)***	**Date**	**Time**
Witness Signature	**Date**	**Time**