LFC FAMILY
HOME HEALTH SOLUTIONS

COVID-19 QUESTIONNAIRE

Date _____/_____/_____

Have you been tested for COVID-19? ☐ Yes ☐ No

If yes what was the date of the test? _____/_____/_____

Results ☐ Negative ☐ Positive

Have you been in contact with anyone awaiting their test results? ☐ Yes ☐ No

Have you been in contact with anyone who tested positive? ☐ Yes ☐ No

Do you have any of the following symptoms:

☐ Coughing ☐ Sore Throat ☐ Headaches

☐ Fever ☐ Shortness of Breath ☐ Runny Nose

☐ Diarrhea

Patient Name: _____

Patient Signature: _____