

COVID 19 Questionnaires

version 3/30/2020

Patient Name: _____

Urgent Care Assessment

- 1) Pain scale 1-10? # _____
- 2) Concern for pain or swelling? Y N
- 3) Ability to function, eat, chew, speak, etc Y N

Current Health

- 1) Do you feel sick? Fever chills, constant cough, temperature, etc Y N
if Yes, explain
- 2) Do you have any respiratory illness or immune compromised Y N
If Yes, explain

Travel/Quarantine

- 1) Have you been quarantined, by self or ordered over the past month Y N
if Yes, explain
- 2) Have you traveled outside of the United States in last 3 weeks Y N
if Yes, explain
- 3) Have you been with family or friends that have traveled outside Y N
of the United States in last 3 weeks?
If Yes explain
- 4) Have you traveled outside of NH or VT in last 2 weeks Y N
if Yes, explain
- 5) Have you been with family or friends that have traveled outside Y N
of NH or VT in last 2 weeks?
If Yes explain
- 6) Do you have any respiratory illness or immune deficiencies Y N
If Yes, explain