Patient Screening

Do you have a fever? or have you felt hot or feverish recently (14-21 days)? *

Yes	No

Are you having shortness of breath or other difficulties breathing? *

Yes	No

Do you have a cough? *

Yes	No

Do you have any flu-like symptoms, such as gastrointestinal upset, headache or fatigue? *

Yes	No

Have you experienced recent loss of taste or smell? *

Yes	No

Have you had any contact with any confirmed COVID-19 positive patients? *

Yes	No

Is your age over 60? *

Yes	No

Do you have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders? *

Yes	No

Have you traveled in the past 14 days to any regions affected by COVID-19? *

Yes	No

Signature *

Draw

Sign here

Date: July 23, 2026 at 2:38 PM

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