Teaneck Gastroenterology Associates, PA
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COVID 19 QUESTIONNAIRE

DATE: ____________________________

Patient Name: ____ DOB: ___________________

Have you or anyone in your household in the last two weeks had any symptoms of Covid-19 including:

Fever ☐

cough ☐

shortness of breath ☐

shaking chills ☐

sore throat ☐

runny nose ☐

muscle aches, headache or flu like symptoms ☐

nausea, vomiting or diarrhea ☐

recent loss of taste or smell? ☐

Have you been caring for someone who is ill or instructed by a healthcare professional to quarantine? ☐

Have you had any travel in the past two weeks, domestically or internationally to areas where covid is spreading? ☐

☐ NO SYMPTOMS OR EXPOSURES

Signature: ____ Date: _______________________