FLORIDA
PLASTIC SURGERY

COVID-19 Medical Questionnaire

1. Have you been tested for COVID-19 and when?

   Yes or No Date: _____

2. Have you had COVID-19 and if so when?

   Yes or No Date: _____

3. In the last 14 days have you had contact with someone with or under investigation for COVID-19?

   Yes or No Date: _____

4. Do you have any of the following symptoms. Please circle:

Fever	**Muscle Pain**
Headache	**Shortness of Breath**
Sore Throat	**Repeated shaking with chills**
Cough	**New loss of taste or smell**

5. Have you been to one of the “hot spots” ie: New York, New Orleans or traveled outside of the country in the last 14 days?
   If so when?

   Yes or No Date: _____

I attested that the answers I gave above are truthful and correct.

_____Date:_____
Name of Patient

_____Date:_____
Witness