## Respiratory Illness Signs & Symptoms Questionnaire for Patients

| **Please answer YES or NO to the following questions:** | **Please circle your response:** |
|---|---|
| Have you recently felt feverish? Current or Recent Fever greater than 100.4 F (38 C) | YES NO |
| Do you have a cough (not related to allergy or chronic lung disease)? | YES NO |
| Are you experiencing shortness of breath? | YES NO |
| Are you experiencing chills, repeated shaking with chills, muscle pain, headache, sore throat, or new loss of taste or smell? | YES NO |
| Have you been in close contact with any person who may be sick with an influenza-like illness, coronavirus, Ebola, measles, MERS, SARS or TB? | YES NO |
| Have you or anyone close to you traveled outside the US in the past 30 days? | YES NO |
| If yes: Name of Country and When | |
| Have you or anyone close to you traveled to another state in the US in the past 30 days? | YES NO |
| If yes: Name of State and When | |

Today's Date _____ Time _____

Patient Signature_____