VIRGIN ISLANDS GASTROENTEROLOGY

Paragon Medical Building, Suite 208
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(340) 714-1122 (*Tel*)
(340) 715-4313 (*Fax*)

Patient Name: _____

Patient COVID Questionnaire

Have you had testing for COVID-19? If yes, please indicate if this was a swab test or the blood antibody test in the line provided. _____	Yes	No
If tested, was your test positive?	Yes	No

If yes, when was the test taken? _____

Please indicate if you have any of the following symptoms within the **past two weeks:**

Fever of 100.4 degrees or higher	Yes	No
Chills	Yes	No
Cough	Yes	No
Shortness of breath, difficulty breathing, chest pain	Yes	No
Sore throat	Yes	No
Loss of sense of smell or taste	Yes	No
New onset of fatigue or lack of energy	Yes	No
Muscle Pain/Body aches	Yes	No
Nausea with or without vomiting	Yes	No
Headache	Yes	No
Congestion or runny nose	Yes	No
New Onset of Diarrhea	Yes	No
Within the last two weeks, have you traveled outside of the territory?	Yes	No
Within the past two weeks, have you been in contact with any person that has been diagnosed with the Coronavirus?	Yes	No

_____ _____

SIGNATURE DATE