North Main Medical
3094 N. Main Street
Crossville,TN 38555
931-644-5423

CORONAVIRUS QUESTIONNAIRE

Patient

Name______________________________DOB___________

1. Do you or anyone in your household have any of the following symptoms
2. Fever
3. Cough
4. Shortness of Breath
5. Loss of taste or smell

Have you traveled in the last 2 weeks?

YES **NO**

Where _____________________________

Have you or anyone in the household been tested for Covid-19 in the last 10 days?

YES **NO**

If yes, Result ____________________

Patient Signature _______________________________Date____________________

Reviewed by: ____________________________________

Date____