TOP AID
HEALTHCARE, INC

COVID 19 Questionnaire/Cuestionario COVID-19

Patient Name/Nombre del Paciente: _____
Name of Person answering the questions (if other than client)/Nombre de la person a que esta contestando las preguntos (sies otro(a) que no sea el cliente:_____

Self-Declaration by Client or Client Representative/Declaracion propia del cliente o representante del cliente.

1. Have you experienced any cold or flu like symptoms in the last 14 days(to include fever over 100 3 degrees, cough, sob, sore throat, respiratory illness, difficulty breathing?)/ H a tenido refriados o sintomas de flu en los ultimos 14 dias (incluyendo fiebre sobre 100.3 grados, tos, dolor de garganta, problemas respiratorios, dificultad con la respiracion?)
   - ❑ Yes/Sl
   - ❑ No
   - ❑ Unknowm/Desconozco

2. Have you traveled to an affected area outside of the US in the past 10 days? /Ha viajado a un area afectada fuera de los EU en los ultimos 14 dias?
   - ❑ Yes/Si
   - ❑ No
   - ❑ Unknown Desconozco

3. Have you been close to an affected area outside the US in the past 14 days? /Ha estado usted cerca a areas afectadas fuera de los EU en los ulitmos 14 dias?
   - ❑ Yes/Si
   - ❑ No
   - ❑ Unknown Desconozco

4. Have you had close contact with a person diagnosed with COVID-19 in the past 14 days?
   /Has estado en contacto cercano de una persona diagnosticado con COVID-19 en los ultimos 14 dias?
   - ❑ Yes/Si
   - ❑ No
   - ❑ Unknown Desconozco

5. Have you been diagnosed with COVID-19 or told by a healthcare provider that you might have COVID-19 Ha sido usted diagnosticado con COVID 19 o ha sido informado por un proveedor medico que pueda que tenga COVID 19?
   - ❑ Yes/Si
   - ❑ No
   - ❑ Unknown Desconozco