DESERT HILLS
PLASTIC SURGERY CENTER

COVID-19 QUESTIONNAIRE

Have you had an exposure to COVID-19? Yes No

Have you recently traveled? Yes No

If so, where?_____

REVIEW OF SYSTEMS

Fever or chills Yes No

Cough Yes No

Shortness of breath or difficulty breathing Yes No

Fatigue, muscle or body aches Yes No

Headache Yes No

New loss of taste or smell Yes No

Sore throat Yes No

Congestion or runny nose Yes No

Nausea, vomiting or diarrhea Yes No

Print Name _____ Date _____

Patient Signature _____