

# Trio Home Health Care of San Diego

## COVID-19 Patient Questionnaire

**Patient Name (Print):** \_\_\_\_\_

**As part of our efforts to monitor the progress of the COVID-19 virus, we would need to ask the following questions prior to providing patient care:**

1. Have you or anyone in your household traveled abroad in the last 14 days?	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>
2. Do you currently have any of the following symptoms: fever (temp 100 degrees or above), cough, sore throat, and/or shortness of breath?	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>
3. Have you been diagnosed with or exposed to anyone diagnosed with <b>COVID-19</b> ?	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>
4. Do you have reason to believe that you, or someone in your household or someone who you are/or have been in close contact with, has been exposed to <b>COVID-19</b> ?	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>

**Follow-up needed**                      \_\_\_ **Yes**    \_\_\_ **No**

**I have informed the patient of the importance of monitoring the above symptoms and to inform an agency staff member or caregiver if they occur prior to receiving care, and have reviewed the Patient Instructions for Infection Control in the Home.**

\_\_\_\_\_  
*Employee Signature*

\_\_\_\_\_  
*Date*