GIG HARBOR
EYE CARE

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COVID-19 SYMPTOMS SURVEY

Have you tested positive for COVID-19?

☐ Yes (If yes, when? _____) ☐ No

Have you been tested for COVID-19 but have not received your results?

☐ Yes (If yes, when? _____) ☐ No

Have you experienced any of these symptoms in the last two weeks?

☐ Fever ☐ Muscle Pain

☐ Cough ☐ Headache

☐ Shortness of Breath ☐ Sore Throat

☐ Difficulty Breathing ☐ Loss of Taste

☐ Chills ☐ Loss of Smell

Have you been in contact with a lab-confirmed COVID-19 patient?

☐ Yes (If yes, when? _____) ☐ No