LANSDOWNE
INTERNAL MEDICINE

224-D Cornwall Street
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Leesburg, VA 20176

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Name:_____ **Date of Birth:**_____

COVID-19 Symptom Checklist

Have you or anyone in your household experienced any of the following symptoms (currently) or in the past 14 days?

Please circle Yes or No

Yes No Cough (dry)
Yes No Fever (=>100.0)
Yes No Chills
Yes No Tiredness (acute, more than usual)
Yes No Shortness of Breath
Yes No Chest Pain
Yes No Sore Throat
Yes No Headache
Yes No Muscle Ache (acute, more than usual)
Yes No Diarrhea
Yes No Nausea
Yes No Vomiting
Yes No Loss of Smell
Yes No Loss of Taste
Yes No Rash (new)
Yes No Acute Numbness or Weakness
Yes No Pink Eye
Yes No Discoloration of fingers or toes
Yes No Abdominal Pain

Please answer for yourself and anyone in your household in the past 14 days:

Yes No Contact with any known or suspected COVID 19?
Yes No Travel out of the state? If yes where?_____
Yes No Have a pending COVID 19 test? If yes where?_____

Signature_____ **Date**_____