NTU Veterinary Teaching Hospital COVID-19 Visitor Questionnaire

Name:_____ Date:_____

Reason for Visit: _____

The questions below pertain to the **last 14 days**:

1. Do you have a fever of 98.7°F or greater today or have you felt hot or feverish in the last 14 days? □Yes □No
2. Have you experienced rapid shaking or chills in the last 14 days? □Yes □No
3. Have you had difficulty breathing in the last 14 days? □Yes □No
4. Have you had shortness of breath in the last 14 days? □Yes □No
5. Have you had a cough in the last 14 days? □Yes □No
6. Are you feeling less than 100% today? □Yes □No
7. Do you have any of the following symptoms in the last 14 days?

   Sore throat □Yes □No
   Headache □Yes □No
   Fatigue □Yes □No
   Muscle pain □Yes □No
   Loss of taste □Yes □No
   Loss of smell □Yes □No
   Gastrointestinal upset □Yes □No

8. Have you been in contact with any COVID-19 positive patients in the last 14 days? □Yes □No
9. Have you been to any known hotspots affected by COVID-19 in the past 14 days? (as relevant to your location). □Yes □No

10. Have you traveled out of the reservation in the past 14 days? □Yes □No

11. If you answered "**yes**" to any of the questions above, please indicate the date(s) you felt the symptoms next to the question.

If you answered YES to any of these questions, please do NOT enter the building. Let a staff member know immediately. Positive responses to any of these require immediate discussion with Director before entering, please call 505-786-4150.

Temperature taken _____ at _____ AM PM

Temperature taken _____ at _____ AM PM

Temperature taken _____ at _____ AM PM

_____ _____

Visitor Signature Reviewed by Director/Date