Radiology Services of New York COVID-19 Patient Questionnaire.

Patient's Name (Last, First) ---------- Date ----------

To prevent the spread of COVID-19 we are conducting a questionnaire. Your cooperation is important to protect you and everyone in this building.

Within the last 14 days have experienced any of the following. Please check all that applies to you.

- ❑ Cough Yes___ No___
- ❑ Shortness of breath Yes___ No___
- ❑ Fever Yes___ No___
- ❑ Loss of taste Yes___ No___
- ❑ Chills Yes___ No___
- ❑ Muscle ache Yes___ No___
- ❑ Headache Yes___ No___
- ❑ Sore Throat Yes___ No___
- ❑ Repeated shaking with chills Yes___ No___

Signature (patient): _____ Date: _____