COUGH FORM

Cough Questionnaire **Date____/____/_____**

First and Last Name _____

Email _____

Phone _____

How long have you had a cough? _____

Are you currently experiencing any symptoms besides coughing?_____

Fever_____

Chills_____

Breathlessness_____

Nausea_____

Diarrhea_____

Fatigue_____

Lack of appetite_____

Loss of smell/taste_____

Stuffed/runny nose_____

Sore throat_____

Body aches_____

Have you been tested for COVID-19, and if so, was the test result?_____

Anyone else in your household with similar symptoms?_____

List any allergies_____

Any pre-existing health disorder? What?_____

Medications you are taking_____

Describe relevant family health history_____

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