QUESTIONNAIRE COVID-19

Corporate name or denomination: Hospital CER **RFC:** SUAL66072019A

Date: ____/____/_____

Please Fill the box with a "Yes" or "No"

Questions:	Yes	No
Have you traveled or been in contact with anyone who have traveled in the last two months?		
Have you been in contact with anyone with COVID-19 in the last 14 days?		
Do you work in airport/health/receptionist or any other work that heavily relies in human contact?		
Fever (100F, 37.5C)		
Shortness of Breath		
Muscle Soreness		
Nausea		
Vomit		
Diarrhea		
Loss of Appetite		
Loss of Smell		
Irritation in the Eye area		
Chronic Fatigue		
Nasal Congestion		
Headache		
Older than 65 years		