tfc Texas Fertility Center

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Board Certified in Reproductive Endocrinology and Infertility
Board Certified in Obstetrics and Gynecology

COVID-19 Coronavirus Patient Self-Assessment Tool

We appreciate your answering these questions each time you visit our office.

Patient Name:_____Date_____

1. Have you had symptoms of: fever, cough, shortness of breath, fatigue, muscle or body aches, headache, new loss of taste smell, sore throat, congestion, or runny nose, nausea or vomiting, diarrhea? ❒Yes ❒No
2. Have you recently traveled? ❒Yes ❒No
   a. If yes, where and when?_____
3. Have you been in close contact with anyone known or suspected to have the COVID-19 coronavirus illness? *Close contact is defined as within 6 feet or for 3 minutes or more.* ❒Yes ❒No
4. Are you or anyone you have been in close contact with currently waiting on COVID test results? ❒Yes ❒No

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Partner Name:_____Date_____

1. Have you had symptoms of: fever, cough, shortness of breath, fatigue, muscle or body aches, headache, new loss of taste smell, sore throat, congestion, or runny nose, nausea or vomiting, diarrhea? ❒Yes ❒No
2. Have you recently traveled? ❒Yes ❒No
   a. If yes, where and when?_____
3. Have you been in close contact with anyone known or suspected to have the COVID-19 coronavirus illness? *Close contact is defined as within 6 feet or for 3 minutes or more.* ❒Yes ❒No
4. Are you or anyone you have been in close contact with currently waiting on COVID test results? ❒Yes ❒No

TFC Staff Member:_____

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