Name: _____

Please indicate **yes** or **no** to any of the following symptoms that you currently have or had in the last 30 days:

_____	Fever	_____	Fatigue
_____	Chills	_____	Headaches
_____	Cough	_____	Sore Throat
_____	Muscle or Body Aches	_____	Difficulty Breathing
_____	Shortness of breath	_____	Loss of Taste or Smell
_____	Congestion	_____	Nausea or Vomiting
_____	Runny Nose	_____	Diarrhea

Please indicate the following and explain.

1. Do you regularly take antihistamines? _____ What do you take and how often?

2. Do you have asthma or suffer from allergies? _____
3. Have you had Covid-19? _____
4. Have you been around any person diagnosed with Covid-19? _____
5. Do you wear a mask regularly when in public? _____
6. Do you wear eye protection when in public? _____
7. Are you practicing socially distancing? _____
8. Have you traveled out of the State of Oklahoma in the last 30 days? ____ Where?

_____

_____ _____

Date Signature