NYS DOH Requirement- Employment/Method of Travel

Patient Name :_____**DOB:**_____

PATIENT INFORMATION

Employment status: ☐ Full time ☐ Part time ☐ Disabled ☐ Retired ☐ Not Employed
☐ Veteran ☐ On Active Military Duty ☐ Self-Employed
☐ Student: Full time/Part time (circle)

Are you an essential worker?: ☐ Yes ☐ No

Method of transportation (work/personal use): ☐ Personal car ☐ Car service ☐ Medical transportation
☐ Public transportation ☐ Walking ☐ Biking ☐ N/A (work from home)

Occupation: _____

Employer Name: _____

Employer Phone Number: _____

Employer Address: _____

_____

CORONAVIRUS QUESTIONNAIRE

1. Have you had any of these symptoms in the past 14 days? Fever, cough, shortness ofbreath, sore throat, chills, loss of taste or smell? Do you live with someone that has these symptoms?
   ☐ YES ☐ NO
2. Have you been diagnosed with COVID 19 in the past 14 days?
   ☐ YES ☐ NO
3. Have you had direct contact with someone that tested positive for COVID 19 in the past 14days?
   ☐ YES ☐ NO
4. Have you had contact with someone that has COVID-19 symptoms but has not been diagnosed?
   ☐ YES ☐ NO
5. Have you been tested for COVID in the last two weeks?
   ☐ YES ☐ NO If yes, date of test? _____ Test result: _____
6. Are you planning to get tested for COVID?
   ☐ YES ☐ NO
7. Have you traveled in the past 14 days?
   ☐ YES ☐ NO If yes, please specify where: _____
8. Have you been social distancing and wearing a mask when you go out of your home over the past 14 days?
   ☐ YES ☐ NO