

Daily Health Monitoring Form

Date:

Name:

Sex:

Age:

Address:

Reason for Visit (if you're a patient):

Body Temperature:

Are you experiencing any of these symptoms?

- **Cough**

Yes

No

- **Fever**

Yes

No

- **Headache**

Yes

No

- **Sore throat**

Yes

No

- **Body pain**

Yes

No

If you're not experiencing any of the symptoms above? Are there any other symptoms you're been experiencing for the past few days or are currently experiencing?

Do you think you may have been exposed to a communicable or contagious disease?

Yes

No

If yes, please elaborate on who, where, when, how, etc.

Signature: