Covid-19 Symptom Monitoring Form

Start Date:

Name:

End Date:

	FEVER/CHILLS	COUGH	SORE THROAT	SHORTNESS OF BREATH	HEADACHE	BODY ACHES	CONGESTION RUNNY NOSE	VOMITING DIARRHEA	LOSS OF SMELL OR TASTE	Temperature
DAY 1	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO
DAY 2	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO
DAY 3	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO
DAY 4	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO
DAY 5	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO
DAY 6	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO
DAY 7	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO
DAY 8	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO
DAY 9	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO
DAY 10	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO