Daily Monitoring Form

Patient information	
Patient name:	**Date of birth:**
Contact information:	**Sex:**
Address:	
Date:	**Body temperature:**
Reason for visit:	

Symptoms (Check all that apply)	
☐ Fever ☐ Cough ☐ Shortness of breath ☐ Fatigue ☐ Muscle or body aches ☐ Loss of taste or smell	☐ Sore throat ☐ Headache ☐ Nausea or vomiting ☐ Diarrhea ☐ Other (Please specify):
Have you been exposed to a communicable disease? ◯ Yes ◯ No	If yes, provide details:
Location:	**Date of exposure:**
Circumstances of exposure:	

Additional notes

FOR OFFICE USE ONLY	
Reviewed by:	**Date reviewed:**
Follow-up required: ◯ Yes ◯ No	