Health Questionnaire

1. Date of birth

Format: M/d/yyyy

2. How do you self-identify?

- ◯ Female
- ◯ Male
- ◯ Non-binary
- ◯ Prefer not to say

3. Please answer the following

	Yes	No
Are you pregnant?	◯	◯
Do you have a fever?	◯	◯
Do you have chills or body aches?	◯	◯
Do you currently have Covid-19 or been exposed in the last 10 days?	◯	◯

4. Overall, how would you classify your health?

- ◯ Excellent
- ◯ Very good
- ◯ Good
- ◯ Fair
- ◯ Poor

5. Please list all medications you are currently taking and for what reasons.

6. Are you currently vaccinated for Covid-19?

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