Required COVID Questionnaire

1) Have you ever been diagnosed with COVID-19 and or its variants?
   YES or NO
   If you answered yes to question number 1, please answer the following questions...

2) Were you hospitalized for COVID?
   YES or NO
   If yes, please explain __________________________________________________________
   ___________________________________________________________________________

3) With your COVID illness, did you have 4 or more days of fever?
   YES or NO
   If yes, how many days? __________________

4) With your COVID illness, did you have 7 or more days of chills and/or body aches?
   YES or NO
   If yes, now many days? __________________

5) With either the COVID illness OR with return to exercises, did you develop any of the following symptoms?
   a. Chest pain? YES or NO
   b. Shortness of breath (beyond that expected of deconditioning and/or out of proportion
      for an upper respiratory tract infection/cold)? YES or NO
      If yes, please explain ______________________________________________________
      _________________________________________________________________________
   c. New palpitations (heart fluttering/beating too fast/beating too slow)? YES or NO
      If yes, please explain_______________________________________________________
      _________________________________________________________________________
   d. Fainting? YES or NO