COVID-19 SCREENING QUESTIONNAIRE

Name____

(if update is needed) Email address: ____

Date _______

1. Have you traveled outside of United States in the last 14 days?
2. Have you had contact with anyone with confirmed Covid-19 in the last 14 days?
3. Have you had any of these symptoms in the last 14 days?
   _____Shortness of breath that you cannot attribute to another health condition?
   _____Chills that you cannot attribute to another health condition?
   _____Cough that you cannot attribute to another health condition?
   _____Fever that you cannot attribute to another health condition?
   _____Headache that you cannot attribute to another health condition?
   _____Muscle Aches that you cannot attribute to another health condition?
   _____Fatigue that you cannot attribute to another health condition?
   _____Sore throat that you cannot attribute to another health condition?
   _____Diarrhea that you cannot attribute to another health condition?
   _____Nausea that you cannot attribute to another health condition?
   _____Vomiting that you cannot attribute to another health condition?
   _____Loss of smell that you cannot attribute to another health condition?
   _____Loss of taste that you cannot attribute to another health condition?
   _____Has your family or any acquaintance had any of the above conditions?
   _____**NONE**

4. Are you currently sick and/or experiencing any of the above _______________?

Signed____