COVID-19 Questionnaire

1) Are you experiencing any of the following symptoms: (please circle)

Fever, chills, sweating?	Yes	No
New or worsening cough?	Yes	No
Fatigue/Body Aches?	Yes	No
Diarrhea?	Yes	No
Reduced Sense of Smell/Taste?	Yes	No
Mild or Moderate Difficulty Breathing?	Yes	No
Sore Throat?	Yes	No
Runny Nose?	Yes	No

2) Have you been told by a health official that you may have been exposed to COVID-19 (coronavirus)? Yes No

3) Have you been around someone who is known to have COVID-19? Yes No

4) In the last 14 days, have you been in an area of high-risk for COVID-19? Yes No

5) In the last 14 days, have you traveled internationally? Yes No

6) Do you live or work in a care facility? (This includes a hospital, emergency room, other medical setting or long-term care facility) Yes No

7) COVID-19 can affect people who have weaker immune systems from things like chemotherapy, HIV/AIDS, organ transplant, being pregnant, or prolonged steroid use. Do you have a weakened immune system from a known cause? Yes No