Questionnaire

** indicates a required field*

COVID-19 Client Screening Questionnaire

Symptom Check

Have you or anyone in your household experienced any of the following symptoms in the last 21 days?

* Fever over 100°F

- Yes
- No

* Cough

- Yes
- No

* Chills

- Yes
- No

* Sore throat

- Yes
- No

* Body aches

- Yes
- No

*** Shortness of breath**

- Yes
- No

*** Loss of smell or taste**

- Yes
- No

Lifestyle Questions

*** Have you or anyone in your household been tested for COVID-19?**

- Yes, and I am awaiting test results
- Yes, and I have received the results
- No

*** Have you or anyone in your household visited or received treatment in a hospital, nursing home, long-term care, or other health care facility in the last 30 days?**

- Yes
- No

*** Have you or anyone in your household traveled within or outside of the U.S. in the last 21 days?**

- Yes
- No

*** Have you or anyone in your household traveled on a cruise ship in the last 21 days?**

- Yes
- No

*** Are you or anyone in your household a health care provider or emergency responder?**

- Yes
- No

*** Have you or anyone in your household cared for an individual who is in quarantine or has tested positive for COVID-19 in the last 21 days?**

- Yes
- No

*** Have you been in close proximity to any individual who tested positive for COVID-19 in the last 21 days?**

- Yes
- No

*** Do you have any reason to believe you or anyone in your household has been exposed to or acquired COVID-19?**

- Yes
- No

* **I agree that I have answered all of the above questions to the best of my knowledge.** _____

I consent to sharing information provided here.

Source: American Medical Association