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COVID-19 Questionnaire

1. Have you experienced any of the following symptoms in the past 48 hours:
• fever or chills • cough • shortness of breath or difficulty breathing • fatigue • muscle or body aches • headache • new loss of taste or smell • sore throat • congestion or runny nose • nausea or vomiting • diarrhea
YES / NO

2. Are you isolating or quarantining because you tested positive for COVID-19 or are worried that you may be sick with COVID-19?
YES / NO

3. Are you fully vaccinated OR have you recovered from a documented COVID-19 infection in the last 3 months? To be considered fully vaccinated, you must be ≥2 weeks following receipt of the second dose in a 2-dose series or ≥2 weeks following receipt of one dose of a single-dose vaccine.
YES / NO

4. Have you been in close physical contact in the last 14 days with: • Anyone who is known to have laboratory-confirmed COVID-19? OR • Anyone who has any symptoms consistent with COVID-19?
YES / NO

5. Are you currently waiting on the results of a COVID-19 test? IMPORTANT: ANSWER "NO" IF YOU ARE WAITING ON THE RESULTS OF A PRE-TRAVEL OR POST-TRAVEL COVID-19 TEST
YES / NO

6. Have you traveled in the past 10 days? Travel is defined as any trip that is overnight AND on public transportation (plane, train, bus, Uber, Lyft, cab, etc.) OR any trip that is overnight AND with people who are not in your household.
YES / NO

Name Printed_____ Signature_____ Date:_____