UNIVERSAL SYMPTOM SCREENING

NAME: _____ DOB: _____ DATE: _____

1. HAVE YOU HAD CLOSE CONTACT (greater than 15 minutes face-to-face at less than 6 feet distance) WITH A PERSON KNOWN TO HAVE LABORATORY CONFIRMED CORONAVIRUS IN THE LAST 14 DAYS?

   ☐ YES ☐ NO

   If yes, were you wearing appropriate PPE (Personal Protective Equipment – Medical Grade)

   ☐ YES ☐ NO

2. ARE YOU EXPERIENCING ANY OF THE FOLLOWING SYMPTOMS?:

FEVER	☐ YES	☐ NO
SHORTNESS OF BREATH	☐ YES	☐ NO
CHEST TIGHTNESS	☐ YES	☐ NO
COUGH	☐ YES	☐ NO
BODY ACHES	☐ YES	☐ NO
FATIGUE	☐ YES	☐ NO

3. HAVE YOU BEEN EXPERIENCING A FEVER OF UNKNOWN CAUSE WITH NO OTHER SYMPTOMS?

   ☐ YES ☐ NO

4. HAVE YOU BEEN TESTED FOR COVID-19 (CORONAVIRUS)?

   ☐ YES ☐ NO

5. IF YES, RESULTS WERE:

   ☐ POSITIVE

   ☐ NEGATIVE

   ☐ RESULTS ARE PENDING

Date that your symptoms began: _____ Date of testing: _____