COVID-19 Pre-Screening Form

(Last Name):
(First Name):
(Date of Birth):

Please answer the following:

1. **Have you had contact with anyone suspected of or confirmed with COVID-19 in the last 14 days?**
   _____Yes _____No

2. **Have you or anyone in your household been tested for COVID-19?** _____Yes _____No

   If so, results were: ____ (Negative) ____ (Positive) If positive, date of test: _____

3. **Have you or anyone in your household had any of the following symptoms in the last 14 days?**

   Fever greater than 100 F_____

   Cough _____

   Shortness of breath or difficulty breathing _____

   Fatigue _____

   Muscle or body aches _____

   Diarrhea _____

   Headache _____

   New loss of taste or smell _____

   Sore throat _____

   Congestion or runny nose _____

   Nausea or vomiting _____

4. **Have you or anyone in your household visited or received treatment in a hospital, nursing home, long-term care, or other healthcare facility in the past 14 days?**
   _____Yes _____No

5. **Have you or anyone in your household traveled in the U.S. in the past 14 days?**
   _____Yes _____No

6. **Have you or anyone in your household traveled outside of the U.S. in the past 14 days?**
   _____Yes _____No

7. **Have you or anyone in your household traveled on a cruise ship in the past 14 days?**
   _____Yes _____No

8. **Do you have any reason to believe you or anyone in your household has been exposed to or infected with COVID-19?**
   _____Yes _____No

9. **To the best of your knowledge have you been in close proximity to any individual who tested positive for COVID-19?**
   _____Yes _____No