**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: \_\_\_\_\_\_\_\_\_\_\_\_\_

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

Fever greater than 100 F\_\_\_\_\_\_ Headache \_\_\_\_\_\_\_

Cough \_\_\_\_\_\_ New loss of taste or smell \_\_\_\_\_\_

Shortness of breath or difficulty breathing \_\_\_\_\_\_ Sore throat \_\_\_\_\_\_

Fatigue \_\_\_\_\_\_ Congestion or runny nose \_\_\_\_\_\_

Muscle or body aches \_\_\_\_\_\_ Nausea or vomiting \_\_\_\_\_\_

Diarrhea \_\_\_\_\_\_

1. **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

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

\_\_\_\_\_\_\_\_Yes \_\_\_\_\_\_\_No

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

\_\_\_\_\_\_\_\_Yes \_\_\_\_\_\_\_No

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

\_\_\_\_\_\_\_\_Yes \_\_\_\_\_\_\_No

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

\_\_\_\_\_\_\_\_Yes \_\_\_\_\_\_\_No

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

\_\_\_\_\_\_\_\_Yes \_\_\_\_\_\_\_No