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COVID-19 SCREENING QUESTIONNAIRE

Please read each question carefully. Please alert the receptionist if the answer to any of these questions is yes.

1. *Have you or a member of your household had any of the following symptoms in the last 21 days: sore throat, cough, chills, body aches for unknown reasons, shortness of breath for unknown reasons, loss of smell, loss of taste, fever, temperature at or greater than 100 degrees Fahrenheit?*

2. *Have you or a member of your household been tested positive Covid-19?*

3. *Have you or a member of your household been advised to be tested for Covid-19 and are awaiting results?*

4. *Have you or a member of your household been advised to self-quarantine for Covid-19?*

5. *Have you or a member of your household visited or received treatment in a hospital, nursing home, long-term care of other health care facility in the past 21 days?*

6. *Have you or a member of your household traveled outside the U.S. in the past 21 days?*

7. *Have you or a member of your household traveled by plane in the U.S. in the past 21 days?*

8. *Have you or a member of your household traveled on a cruise ship in the past 21 days?*

9. *Do you have any reason to believe you or a member of your household has been exposed to or acquired Covid-19?*

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

11. *Have you received a Covid-19 vaccine?* *If so, when?*

The answer to all of these questions is no __

The answer to one or more of these questions is yes__

I acknowledge that the answers to these questions are, to the best of my knowledge, true and accurate.

NAME:_____ *SIGNATURE:_____* *DATE:_____*