

## Covid Health Check Questioner

Have you had any prolonged close contact (within 6 feet) with anyone that could be infectious?

No\_\_\_\_ Yes\_\_\_\_

Have you been ill, or do you feel in anyway under the weather now?

No\_\_\_\_ Yes\_\_\_\_

Have you been advised to isolate at any point in the last 14 days?

No\_\_\_\_ Yes\_\_\_\_

Do you feel that you may pose a risk to anyone else here or anyone they might be in contact with at home?

No\_\_\_\_ Yes\_\_\_\_

**COVID-19 Symptoms:** Do you have any of the symptoms listed below?

\_\_\_\_ Cough

\_\_\_\_ Chills

\_\_\_\_ Muscle Pain

\_\_\_\_ Sore throat

\_\_\_\_ Diarrhea

\_\_\_\_ Known close contact with a person who is lab-confirmed to have COVID-19.

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

\_\_\_\_ Repeated shaking with chills

\_\_\_\_ Headache

\_\_\_\_ Loss of taste or smell

\_\_\_\_ Feeling feverish or having a temperature of 100 degrees or more.