**Name**:

**COVID-19 Screening Questions**

Please answer the following:

1. Have you personally tested positive for COVID-19? Yes No

If yes, when?

1. Have you had contact with anyone with confirmed COVID-19? Yes No
2. Have you had any of the following symptoms in the last 14 days?

Yes No

* 1. Fever greater than 100
	2. Difficulty breathing
	3. Cough
1. Are you currently experiencing fever over 100, difficulty breathing, or cough?
	1. Yes
	2. No

*If you answered yes to any of these questions, please call your primary care provider for further directions.*