Public Evaluation for COVID-19

Name:

Date:

Have you had a temperature of 100.4 or higher within the past three days? ☐ Yes ☐ No

Have you had any of the following symptoms within the past three days?

- ☐ Congestion
- ☐ Cough (unrelated to allergies)
- ☐ Diarrhea
- ☐ Eye Drainage
- ☐ Fever / Chills
- ☐ Nausea
- ☐ New loss of sense of taste or smell
- ☐ Runny Nose
- ☐ Shortness of Breath
- ☐ Sore throat (unrelated to allergies)
- ☐ Unusual muscle pain
- ☐ Unusual Fatigue
- ☐ Vomiting
- ☐ Worsening / consistent headaches
- ☐ None of the Above

Over the past 14 days have you been in close contact with any person who has tested positive for COVID-19? ☐ Yes ☐ No

Over the past 14 days have you been in close contact with any person who has had symptoms of COVID-19 though they have not been tested? ☐ Yes ☐ No

Have you visited a hospital or long-term care facility in the past 14 days? ☐ Yes ☐ No