Screening Questions

1. Do you have a fever or above-normal temperature (>100F)?
   YES___ NO___
2. Have you taken fever reducers in the past 72 hours?
   YES___ NO___
3. Have you been experiencing shortness of breath or having trouble breathing?
   YES___ NO___
4. In the past 72 hours, have you had a dry cough?
   YES___ NO___
5. In the past 72 hours, have you had a runny nose?
   YES___ NO___
6. In the past 72 hours, have you had a sore throat?
   YES___ NO___
7. Have you recently lost or had a reduction in your sense of smell or taste?
   YES___ NO___
8. In the past 72 hours, have you had any other flu-like symptoms, such as gastrointestinal upset, headache, muscle pain or fatigue?
   YES___ NO___
9. In the past 72 hours, have you had chills or repeated shaking with chills?
   YES___ NO___
10. Have you been tested for COVID-19?
    YES___ NO___

If YES, date tested ________ & what is the result?

_____ Positive       _____ Negative       _____Awaiting result

11. In the last 14 days, have you been in contact with someone who has a confirmed case COVID-19, under investigation for COVID-19 or a respiratory illness?
    YES ___ NO ___

12. In the last 14 days, have you traveled to any foreign country?
    YES ___ NO ___

If YES, where? ______________________________

13. In the last 14 days, have you traveled to a state outside of CA?
    YES ___ NO ___

If YES, where? ______________________________