Coronavirus Screening Questionnaire

Name: ____ MUID: ______________________ Date / Time: _____________________

Address / Residence Hall / Room #:____

Phone #: __________________________________

Risk Assessment: **Initial screening questions are to be completed by phone call the day prior to appointment and reviewed for any changes upon arrival to the appointment.**

		YES	NO
1.	Do you have any of the following symptoms?		
	• Fever > 100.4°F or subjective fever		
	• Cough		
	• Shortness of breath/breathing difficulties		
	• Loss of taste or smell		
	• Other symptoms such as muscle aches, fatigue, headache, sore throat, runny nose, diarrhea, lethargy		
2.	Have you travelled internationally in the last 14 days? ***If yes, please indicate where you traveled: ____**		
3.	Have you had close contact (face-to-face contact within 6 feet) with someone who is ill with a cough and/or fever who has traveled internationally within 14 days prior to their illness onset?		
4.	Have you been in contact in the last 14 days with someone that has a confirmed case of COVID-19?		
5.	Have you traveled on a cruise ship within the last 14 days?		
6.	Have you traveled in the last 14 days domestically (USA) to areas known to have confirmed cases of COVID-19 (i.e. "hot spots")? ***If yes, please indicate where you traveled: ____**		

PRE-SCREENING

Name of staff: ____

Temperature (self-reported): ______________ Date of symptom(s) onset: ________________________

Date: __________________________________ Time: ______________ AM PM

DAY OF ARRIVAL TO APPOINTMENT

Temperature taken upon arrival at Welcome Center: ______________

Any reported changes to initial screening questions: ____

Date: __________________________________ Time: ______________ AM/PM

Name of person taking temperature/reviewing screening questions: ____