NAME _____ NAME _____ NAME _____
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1. Do you have a new cough that you cannot attribute to another health condition?	Yes / No
2. Do you have shortness of breath that you cannot attribute to another health condition?	Yes / No
3. Do you have a headache that you cannot attribute to another health condition?	Yes / No
4. Do you have a runny nose or congestion that you cannot attribute to another health condition?	Yes / No
5. Do you have any of the following symptoms: fever, chills, repeated shaking with chills, muscle pain, nasal congestion, sore throat, nausea, vomiting, diarrhea or new loss of taste or smell?	Yes / No
6. Have you come into close contact (within 6 feet) with someone who has a laboratory-confirmed COVID-19 diagnosis in the past 14 days?	Yes / No
7. Has a health care provider or public health official asked you to quarantine (i.e., stay home) during this period?	Yes / No

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