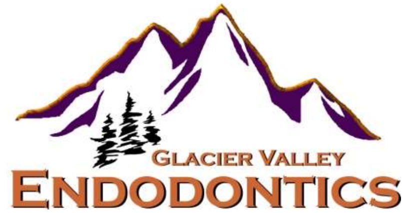

Novel Coronavirus Disease (Covid-19) Screening Questionnaire (Please initial next to each response)

1.) ARE YOU CURRENTLY AWAITING THE RESULTS OF A COVID-19 TEST? _______YES_______NO
2.) DO YOU HAVE A FEVER? ______YES_______ NO
3.) DO YOU HAVE ANY SHORTNESS OF BREATH? _______YES_______ NO
4.) DO YOU HAVE A DRY COUGH? _______YES _______NO
5.) DO YOU HAVE A RUNNY NOSE? _______YES _______ NO
6.) DO YOU HAVE A SORE THROAT? ________YES _______NO
7.) DO YOU HAVE SNEEZING, WATERY EYES, AND/OR SINUS PAIN/PRESSURE THAT IS UNUSUAL AND NOT RELATED TO SEASONAL ALLERGIES? _______YES_______ NO
8.) HAVE YOU EXPERIENCED HEADACHES, FATIGUE, OR WEAKNESS?________YES_______ NO
9.) HAVE YOU LOST YOUR SENSE OF TASTE AND/OR SMELL? ________YES _______NO
10.) WITHIN THE LAST 14 DAYS, HAVE YOU TRAVELLED TO ANY FOREIGN COUNTRY? _______YES_______ NO
11.) WITHIN THE LAST 14 DAYS, HAVE YOU TRAVELLED OUTSIDE OF THE FLATHEAD VALLEY? ______YES ______ NO
IF SO, WHERE?____

_____________________________ Printed Name _________ Date of Birth

_____________________________ Signature ___________Date

For Office Use Only:

____________Temperature

____________ Staff Initials