Health Questionnaire Screening Form for Coronavirus (COVID 19)

Symptoms of COVID-19

People with COVID-19 have had a wide range of symptoms reported – ranging from mild symptoms to severe illness. Symptoms may appear 2-14 days after exposure to the virus. People with these symptoms may have COVID-19 and should not attend school or work.

- Fever or chills
- Cough
- Shortness of breath or difficulty breathing
- Fatigue
- Muscle or body aches
- Headache
- New loss of taste or smell
- Sore throat
- Congestion or runny nose
- Nausea or vomiting
- Diarrhea

Questions for COVID screening:

1. Have you knowingly been in close proximate contact in the past 14 days with anyone who has tested positive for COVID 19?
2. Have you tested positive for COVID 19 in the last 14 days?
3. Have you experienced any symptoms of COVID 19 in the past 14 days?
4. In the last 14 days, have you traveled from another state or country for which New York requires a mandatory self-quarantine period?
5. If you answered yes to question #4, have you completed the 14 day self-quarantine as currently required by New York State

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When to Seek Immediate Emergency Medical Attention

Look for emergency warning signs* for COVID-19. If someone is showing any of these signs, seek emergency medical care immediately:

- Trouble breathing
- Persistent pain or pressure in the chest
- New confusion
- Inability to wake or stay awake
- Bluish lips or face

*This list is not all possible symptoms. Please call your medical provider for any other symptoms that are severe or concerning to you. Call 911 or call ahead to your local emergency facility: Notify the operator that you are seeking care for someone who has or may have COVID-19.

OVER THE PAST 14 DAYS, HAVE YOU EXPERIENCED ANY OF THE FOLLOWING:

Date	**Employee self-screened prior to coming to work? (Temp under 100.4, No Symptoms, or Positive test/ contact)** **Yes or No***	**Question 1: COVID-19 Symptoms: Temp over 100.4, Respiratory Issues, Chills, Loss of Taste or Smell, Muscle Aches** **Yes* or No**	**Question 2: Positive COVID-19 Test** **Yes* or No**	**Question 3: Contact with Confirmed or Suspected COVID-19 Case** **Yes* or No**	**I attest all the information is true.** **Initials**
M					
T					
W					
Th					
F					

Date Questionnaire was completed: _____
Initials:_____