COVID-19
Health Screening Questions

07-24-2020

1 **Have you had any of these signs or symptoms:**

- respiratory infection
- fever
- cough
- shortness of breath
- sore throat
- chills, repeated shaking with chills
- muscle pain
- loss of taste or smell

2 **Do you have COVID-19, or does someone in your household** (family member or roommate) **have COVID-19?**

3 **Have you had contact with someone** (friend, classmate) **with a confirmed diagnosis of COVID-19?**

4 **Does anyone in your household** (family member or roommate) **have a COVID-19 test pending?**

5 **Does anyone in your household** (family member or roommate) **have respiratory illness?**

6 **Do you consider yourself as being in the high-risk category for COVID-19 as defined by the CDC?** High risk – older adult (65 or older) with a serious chronic medical condition, a chronic disease such as heart disease, diabetes, lung disease, immuno-compromised disease, liver disease, chronic kidney disease, are receiving treatments that may compromise one's immune system, are pregnant?