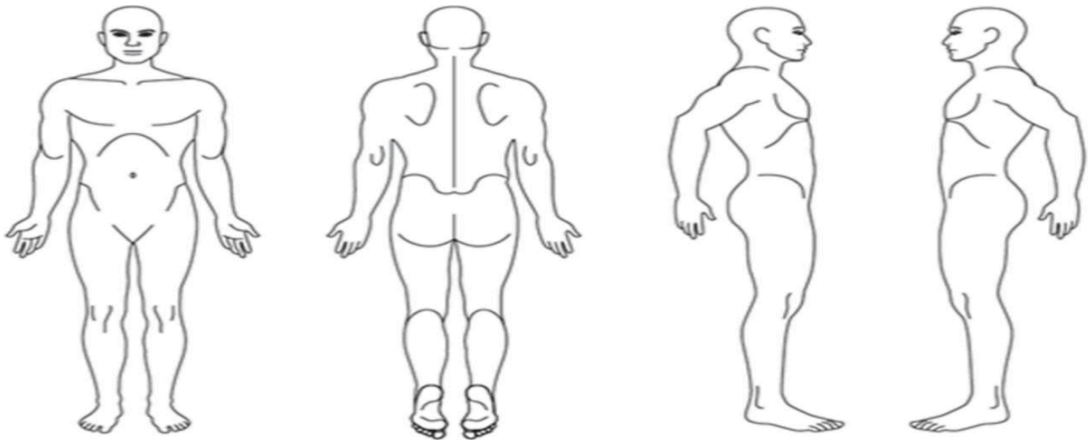
COVID-19 SCREENING CHECKLIST

1. Have you recently or currently experienced any of the following symptoms in the past 14 days? (check all that apply)
   - ◯ Fever (at or above 100.4 degrees Fahrenheit)
   - ◯ Chills
   - ◯ Cough
   - ◯ Shortness of breath/difficulty breathing
   - ◯ New loss of taste or smell
   - ◯ Sore throat
   - ◯ Headache
   - ◯ Congestion or runny nose
   - ◯ Muscle or body aches
   - ◯ Fatigue
   - ◯ Nausea/Vomiting/Diarrhea
2. Have you or anyone in your household been tested for COVID-19? ◯ Yes ◯ No →
   If so, <u>when</u> was the test and <u>what</u> were their results? _____
3. Is anyone in your household currently under quarantine? ◯ Yes ◯ No
   → If so, who? _____
4. Do you believe a member of your household has been exposed to COVID-19? ◯ Yes ◯ No →
   If so, who? _____
5. Have you been vaccinated against COVID-19? ◯ Yes ◯ No
   → If so, when was your most recent injection? _____/_____/_____
   → If not, when is your vaccination appointment scheduled? _____/_____/_____

<u>Indicate Your Pain on Body Picture and Circle the Face that Represents Your Pain Level Below</u>



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