COVID-19 Screening Form

Customer's name:________________________
Date:_______________

1. Have you previously been diagnosed with COVID-19,or do you think you've had/have COVID-19?

YES__ NO__
(If NO to question 1, skip to question 5)

2. If YES, when and how were you confirmed positive?
__ I think I had it.
__ I had a positive nasal swab test.
__ I had a positive blood test.
__ I had a positive saliva test.
__ I currently have symptoms and am waiting for a test.

3. If you have had COVID-19, how were you confirmed negative?
__ I was diagnosed negative by a nasal swab test. How many times?__
__ I show antibodies to COVID-19 with a blood test.
__ My doctor said I no longer have it because I don't have any symptoms.
__ I don't have any symptoms,so I don't have it.

4. If you have had COVID-19, when were you confirmed negative?
__ 24 hours ago __ today __ 10 days after testing

5. Do you currently have(or have you experienced)any of the following symptoms in the past 21 days:

- Fever YES__ NO__
- Fatigue (feeling tired) YES__ NO__
- Altered or loss of taste/smell YES__ NO__
- Dry cough YES__ NO__
- Trouble breathing YES__ NO__
- Shortness of breath, difficulty breathing, chest tightness YES__ NO__
- Confusion YES__ NO__
- Blueish lips/or face YES__ NO__
- Chills/repeated shaking with chills YES__ NO __
- Muscle pain YES__ NO__
- Headache or sore throat YES__ NO__
- Any other flu-like symptoms YES__ NO__
- GI upset or diarrhea YES__ NO__

6. Are you in contact with anyone who has been sick and/or confirmed to be COVID-19–positive?
YES__ NO__

7. In the past 14 days have you traveled to any regions affected by COVID-19? Or outside Texas?
YES__ NO__