Name: **Date:**

Screening for Diagnosis of Coronavirus (Covid19) – Please **CIRCLE** the answers

1) Do you have any of the following symptoms?
   Fever
   Cough
   Shortness of Breath
   Aches/Chills
   Sore Throat
   Diarrhea
   Headache

2) Do you have any of these unusual symptoms?
   Loss of taste
   Loss of smell
   Pink eye

3) Have you traveled outside of the country or to New York City in the past 2 weeks?
   Yes or No

4) Have you received a flu vaccine in 2019 or 2020?
   2019 or 2020

5) Have you had a fever in the past 7 days?
   Yes or No

6) Have you had close contact with a known coronavirus patient?
   Yes or No

7) Have you been practicing social distancing?
   Yes or No

8) Have you been wearing a face mask covering your nose AND mouth when out of home?
   Yes or No