VIRAL INFECTION RISK ASSESSMENT

Name: _____ DOB: _____

YES	NO	
		Have you had COVID-19 testing?
		If so, date of testing: Type of test (nasal swab / blood test): Positive or Negative: Reason for testing:
		Have you had contact in the last 2 weeks with someone with lab-confirmed COVID-19 disease?
		Have you or a close contact flown internationally or domestically in the last 2 weeks?
		Have you or a close contact had any of the following in the last 2 weeks?
		Fever of 99.5 F or higher?
		Cough, sore throat, chills, fatigue?
		Shortness of breath or tight feeling in the chest?
		Worsening of usual “allergy” symptoms?
		Nausea, vomiting, or diarrhea?
		Decreased sense of smell?
		Decreased sense of taste?
		“Pneumonia”?
		Flu?
		Strong suspicion of having COVID-19 without laboratory testing?
		Visit to a nurse or physician for other medical concerns? If so, please explain:
		Is there anything else you think we should know?

_____ _____

Signature Date

If completed by phone interview, completed by: