COVID-19 Symptom Screening Checklist

This checklist follows guidance from the Centers for Disease Control and Prevention (CDC) for monitoring symptoms consistent with COVID-19, and exposures to the virus that causes it.

Please fill out and return this checklist.

Printed name:_____

Signature:_____ Date:_____

Do you have any of the following symptoms that are not caused by another condition?	Yes	No
Fever or chills	☐	☐
Cough	☐	☐
Shortness of breath or difficulty breathing	☐	☐
Fatigue	☐	☐
Muscle or body aches	☐	☐
Headache	☐	☐
New loss of taste or smell	☐	☐
Sore throat	☐	☐
Congestion or runny nose	☐	☐
Nausea or vomiting	☐	☐
Diarrhea	☐	☐

Have you recently experienced any of the following COVID-19 emergency warning signs?	Yes	No
Trouble breathing	☐	☐
Persistent pain or pressure in the chest	☐	☐
New confusion	☐	☐
Inability to wake or stay awake	☐	☐
Bluish lips or face	☐	☐

COVID-19 Screening Questions	Yes	No
Within the past 14 days, have you been in close physical contact (6 feet or closer for at least 15 minutes) with a person known to have laboratory-confirmed COVID-19 or with anyone who has any symptoms consistent with COVID-19?	☐	☐
Within the past 14 days, has a public health or health care professional advised you to self-monitor, isolate or quarantine because of concerns about COVID-19 infection?	☐	☐
Have you had a positive COVID-19 test in the past 10 days?	☐	☐