HEALTH SCREENING

YES	NO	Are you exhibiting symptoms of acute respiratory illness?
YES	NO	Do you have flu like symptoms: fever, cough, chills, shortness of breath, gasterointestinal upset, muscle pain, headache, sore throat, fatigue?
YES	NO	Have you experienced a recent loss of smell or taste?
YES	NO	Do you have a history of long distance travel or cruise by plane, train, bus or car within the past 4 weeks?
YES	NO	Do you have a history of heart disease, lung disease, kidney disease, diabetes, or any auto-immune disorders?
YES	NO	Are you staying at home, wearing a mask, practicing social distancing?
YES	NO	Does your workplace involve a high risk environment: hospital, medical clinic,senior assisted living facility?
YES	NO	Have you had close contact with a anyone who has had any of the above mentioned symptoms or has tested positive for COVID-19?
YES	NO	Have you had a recent COVID-19 laboratory test and/or antibody test?
YES	NO	Do you have/had the COVID-19 virus?

Name_____Date_____