



COVID-19

WELLNESS CHECK QUESTIONS

1. Within the last 6 weeks, have you experienced any of the following? No Yes
 - a. cough
 - b. shortness of breath
 - c. sore throat
 - d. fever
2. Within the last 6 weeks, have you had any contact with a COVID-19 patient? No Yes
3. Within the last 6 weeks, have you traveled domestically or internationally? No Yes
4. Within the last 6 weeks, have you traveled to any areas with community transmission of COVID-19? No Yes
5. Do you work in a healthcare facility? No Yes
6. Within the last 6 weeks, have you attended a healthcare facility? No Yes

Signature of patient or if patient is a minor, legal guardian

Date