Date: _____

Name: _____ DOB: _____

Temperature: _____ F

Coronavirus Risk Assessment

(please answer all questions)

In the past 4 weeks have you or someone accompanying you had **new**:

1) cough, wheeze, chest tightness, or shortness of breath? Yes No
2) feverish feeling? Yes No
3) measured temperature above 100F? Yes No
4) chills? Yes No
5) headaches? Yes No
6) sore muscles or joints? Yes No
7) sore throat? Yes No
8) diarrhea? Yes No
9) nausea or vomiting? Yes No
10) extreme fatigue? Yes No
11) abdominal pain? Yes No
12) loss of sense of smell and/or taste Yes No

Have you or someone with you today travelled out of state in the past 2 wks? Yes No

Have you or someone with you today had known exposure to a person with coronavirus? Yes No