## Wellness Services Health Screening

Name: _____

Date: _____

| In the past 24 hours, have you experienced? | | |
|---|---|---|
| Fever | YES | NO |
| Cough | YES | NO |
| Shortness of breath or difficulty breathing | YES | NO |
| Loss of taste or smell | YES | NO |
| | | |

| In the past 24 hours, have you experienced? | | |
|---|---|---|
| Chills | YES | NO |
| Muscle aches | YES | NO |
| Headache | YES | NO |
| Sore throat | YES | NO |
| Fatigue (not otherwise explained by another known cause) | YES | NO |
| Diarrhea | YES | NO |
| Nausea or vomiting | YES | NO |
| Congestion or runny nose | YES | NO |
| | | |

| In the past 14 days, have you: | | |
|---|---|---|
| Been in close contact with anyone diagnosed with COVID-19 or been told that you have been exposed to COVID-19? | YES | NO |
| | | |