Pre-screening Health Questions related to COVID-19

**If the answer to any question below is "yes," please explain which household member(s) are affected and provide as much detail as possible.*

1. In the past 14 days, has anyone in the household been potentially exposed to COVID-19 (close contact with someone who has recently traveled, been diagnosed with the virus and/or shown symptoms, or working in the medical field)?

   ☐Yes ☐ No ☐ Unknown

2. Does anyone in the household have a cough or shortness of breath or difficulty breathing; or at least two of the following symptoms: fever, chills, repeated shaking with chills, muscle pain, headache, sore throat or new loss of taste or smell; and the symptoms could be related to potential exposure to COVID-19?

   ☐ Yes ☐ No ☐ Unknown

3. Has anyone in the household tested positive for COVID-19 in the past 14 days?

   ☐ Yes ☐ No ☐ Unknown

4. Is anyone in the household isolated/quarantined per doctor's orders?

   ☐ Yes ☐ No ☐ Unknown