Member COVID-19 Health Questionnaire

In the past 24 hours, have you experienced:

Fever or chills:

☐ Yes ☐ No

Fatigue:

☐ Yes ☐ No

Cough or Sneezing:

☐ Yes ☐ No

Sore throat:

☐ Yes ☐ No

Aches and Pains:

☐ Yes ☐ No

Runny or Stuffy Nose:

☐ Yes ☐ No

Diarrhea:

☐ Yes ☐ No

Headaches:

☐ Yes ☐ No

Shortness of breath/difficulty breathing:

☐ Yes ☐ No

Loss of sense of taste or smell:

☐ Yes ☐ No

Have you been in close contact with anyone who has exhibited any symptoms in the last

14 days?

☐ Yes ☐ No

Have you been in contact with anyone who has tested positive for COVID-19 in the last 14 days?

☐ Yes ☐ No

Have you recently traveled outside of _____

☐ Yes ☐ No

SIGNATURE: _____ DATE: _____

NAME: _____