

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; <u>and</u> 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