Updated 08/16/20

Clinical Research Study First Point of Contact Screening

(to be assessed at the door with each patient who wishes to enter a University building)

COVID-19 SCREENING QUESTIONNAIRE

Patient Name: **Date:**

TEMPERATURE:

Do you have any of the following symptoms?

- Fever greater than 100.4? ◯ Yes ◯ No
- Chills? ◯ Yes ◯ No
- New cough not related to allergies or COPD? ◯ Yes ◯ No
- Difficulty breathing/ shortness of breath? ◯ Yes ◯ No
- Sore Throat? ◯ Yes ◯ No
- Nasal congestion unrelated to allergies? ◯ Yes ◯ No
- Body aches and pains? ◯ Yes ◯ No
- New headache? ◯ Yes ◯ No
- Nausea or vomiting? ◯ Yes ◯ No
- Diarrhea? ◯ Yes ◯ No
- Loss of or reduction in sense of taste or smell? ◯ Yes ◯ No

In the past 14 days, have you been exposed to individuals who have tested positive or presumed positive for COVID-19? ◯ Yes ◯ No

Have you been tested previously for COVID-19? ◯ Yes ◯ No

Have you tested positive for COVID-19 previously? ◯ Yes ◯ No

In the past 14 days have you traveled outside of the U.S.? ◯ Yes ◯ No

Research Staff Name and Signature: ___________________________

Please Print Your Name: ___________________________