COVID-19 Pre-Screen

1. Are you experiencing ANY of the following emergency symptoms: severe shortness of breath and difficulty breathing, persistent chest pain or pressure, new confusion or inability to arouse, bluish lips or face, loss of consciousness, slurred speech, and/or severe, constant dizziness or lightheadedness?

2. Are you experiencing any of the following symptoms? Please select all that apply.
    - Fever, chills or sweating
    - New or worsening cough
    - Fatigue
    - Body aches
    - Diarrhea
    - Reduced sense of smell and/or taste
    - Mild to moderate difficulty breathing
    - Sore throat
    - Runny nose
    - None of the above

3. Have you been told by a health official that you may have been exposed to COVID-19 (coronavirus)?

4. Have you been around someone who is known to have COVID-19 (coronavirus)?

5. Have you been tested before for COVID-19?

6. In the last 14 days, have you been in an area of high-risk for COVID-19 (coronavirus)?

7. In the last 14 days, have you traveled domestically or internationally? If so, where?

8. Do you live or work in a care facility? (This includes a hospital, emergency room, other medical setting, or long-term facility.)

9. Are you currently working in an industry providing critical services that require you to work on location? (This includes industries such as grocery, banking, childcare, etc.)