THE CENTER AT HAMPTON HOUSE

COVID-19 Questionnaire

Have you experienced any of the following symptoms in the past 48 hours:

- fever or chills
- cough
- shortness of breath or difficulty breathing
- fatigue
- muscle or body aches
- headache
- new loss of taste or smell
- sore throat
- congestion or runny nose
- nausea or vomiting
- diarrhea

_____ YES **_____ NO**

Within the past 14 days, have you been in close physical contact (6 feet or closer for at least 15 minutes) with a person who is known to have laboratory-confirmed COVID-19 or with anyone who has any symptoms consistent with COVID-19?

_____ YES **_____ NO**

Are you isolating or quarantining because you may have been exposed to a person with COVID-19 or are worried that you may be sick with COVID-19?

_____ YES **_____ NO**

Are you currently waiting on the results of a COVID-19 test?

_____ YES **_____ NO**

_____ _____ _____

Participant/Guardian Signature | Printed Name | Today's Date