COVID-19 Self-Screening Form

1) Are you feeling ill? **No / Yes**

2) Do you feel feverish? **No / Yes**

3) Do you have a fever over 100 degrees? **No / Yes**

   Temperature (in °F): _____

4) Are you experiencing any of the following:
   i. Coughing **No / Yes**
   ii. Body aches **No / Yes**
   iii. Shortness of breath **No / Yes**
   iv. Difficulty breathing **No / Yes**
   v. Chest tightness **No / Yes**
   vi. Sore throat or congestion **No / Yes**
   vii. Nausea or vomiting or diarrhea **No / Yes**

5) Do you have a family member at home with symptoms? **No / Yes**

6) Have you had contact with someone diagnosed with COVID-19? **No / Yes**

7) Have you visited a place where COVID-19 is spreading? **No / Yes**

If you answered yes to any of the questions above you should stay at home and follow up with your primary care physician.

MOUNT CARMEL

A Member of Trinity Health