COVID-19 Supplemental Questionnaire

Have you had any of the following symptoms in the past two weeks?

Yes	No	
☐	☐	Fever
☐	☐	Cough
☐	☐	Shortness of breath or difficulty breathing
☐	☐	Fatigue or difficulty with exercise
☐	☐	Racing heart rate
☐	☐	Unusual dizziness
☐	☐	Loss of taste or smell
☐	☐	Sore throat
☐	☐	Nausea, vomiting, or diarrhea
☐	☐	Unusual rash or painful discoloration of fingers or toes
☐	☐	Do you have a family or household member with current or past COVID-19?
☐	☐	Do you have moderate to severe asthma, a heart condition, chronic kidney or liver disease, or take medication or have a medical condition that weakens your immune system?
☐	☐	Have you been diagnosed with or test positive for COVID-19 infection?