**Member COVID-19 Health Questionnaire**

In the past 24 hours, have you experienced:

Fever or chills:

 Yes  No

Fatigue:

 Yes  No

Cough or Sneezing:

 Yes  No

Sore throat:

 Yes  No

Aches and Pains:

 Yes  No

Runny or Stuffy Nose:

 Yes  No

Diarrhea:

 Yes  No

Headaches:

 Yes  No

Shortness of breath/difficulty breathing:

 Yes  No

Loss of sense of taste or smell:

 Yes  No

Have you been in close contact with anyone who has exhibited any symptoms in the last

14 days?

 Yes  No

Have you been in contact with anyone who has tested positive for COVID-19 in the last 14 days?

 Yes  No

Have you recently traveled outside of Insert Your Country Here:

 Yes  No

SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_