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| --- | --- | --- | --- |
| Participant Symptom Screening Questionnaire | | YES | NO |
| 1. | Have you had any of the following symptoms of COVID-19 within the last 14 days?   * + Fever or chills   + Shortness of breath or difficulty breathing   + Cough   + Fatigue   + New loss of smell or taste   + Sore throat   + Muscle or body aches   + Headache   + Congestion or runny nose   + Nausea or vomiting   + Diarrhea |  |  |
| 2. | Has anyone in your household tested positive for COVID-19 within the last 14 days? |  |  |
| 3. | Have you had close contact (within 6 feet for 15 or more minutes) with anyone outside your home who has a confirmed COVID-19 diagnosis or COVID-19 symptoms within the last 14 days? |  |  |
| 4. | Within the past 14 days, has a public health or medical professional told you to self‑monitor, self-isolate, or self-quarantine because of concerns about COVID-19 infection? |  |  |
| 5. | Are you currently waiting for the results of a COVID-19 test? |  |  |

By signing below, I understand the above information regarding COVID-19 and my study visit, and agree that I have answered the Symptom Screening Questionnaire truthfully and to the best of my knowledge.

Name:

Signature:

Date: