University of Cincinnati Public Safety COVID Questionnaire

INFORMATION:

Name (Print): _____ Date/Time: _____

Position/Department: _____

SYMPTOMS:

Temperature (Degrees F): _____

Do you feel like you are getting sick? YES ◯ NO ◯

Do you feel like you have a fever? YES ◯ NO ◯

Please select all current symptoms

☐ None

☐ Shortness of Breath

☐ Dry Cough

☐ Cough with Phlegm (Productive Cough)

☐ Bone or Joint Pain

☐ Sore Throat

☐ Headache

☐ Chills

☐ Nausea or Vomiting

☐ Congestion

☐ Fatigue

☐ Diarrhea

☐ Swollen Eyes

☐ Loss of Appetite

☐ Loss of Smell or Taste

TESTS:

In the past month, have you tested positive for the COVID-19 virus?

YES ◯ NO ◯ UNKNOWN ◯ RESULTS PENDING ◯

CONTACT TRACING:

In the past month, have you encountered anyone who is suspected of having, under investigation, or being tested for COVID-19?

YES ◯ NO ◯

In the past month, have you encountered anyone with flu-like symptoms?

YES ◯ NO ◯