University of Cincinnati Public Safety COVID Questionnaire

NAME (PRINT): ___________________________ DATE/TIME: ____________

POSITION/DEPARTMENT: _____________________________________________

SYMPTOMS:

Temperature (°F): __________

Do you feel like you are getting sick? (Circle one) YES NO

Do you feel like you have a fever? (Circle one) YES NO

Please select all current symptoms (circle all that apply)

• 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 in the past month? (circle one)

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? (circle one)

YES NO

In the past month, have you encountered anyone with flu-like symptoms? (circle one)

YES NO