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