Patient Name _____ Date _____

1. Have you been tested for COVID-19 within the last 14 days? YES NO
2. Have you been in contact with someone who is sick within the last 14 days? YES NO
3. Have you traveled out of North Carolina in the last 14 days? YES NO
4. Have you been in contact with someone who has traveled out of North Carolina in the last 14 days? YES NO
5. Have you been in close contact with another person who has been diagnosed with or under investigation for COVID-19 in the last 14 days? YES NO
6. Do you have any of the following symptoms? YES NO
    a. Fever
    b. Cough
    c. Shortness of breath
    d. Vomiting
    e. Diarrhea

Temperature _____

Patient Signature _____