	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 Couch 		
	 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		
5.	infection? Are you currently waiting for the results of a COVID-19 test?		
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:_____