Symptom Screening Questionnaire

	YES	NO
1. Have you or anyone else in your household had any of the following symptoms in the last fourteen (14) calendar days that were not diagnosed as something other than COVID-19, even if they were mild? • Shortness of breath or difficulty breathing • Chest pressure • Cough • Temperature exceeds 100.4 F when measured with a household thermometer • New loss of smell or taste • Sore throat • Muscle pain • Headache • Congestion or runny nose • Nausea or vomiting • Diarrhea	☐	☐
2. Have you or anyone else in your household tested positive or been diagnosed with COVID-19 at any time? If so, when?	☐	☐
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 infection?	☐	☐
5. In the last 14 days, have you travelled outside of the State of Maine? If so, where?	☐	☐
6. 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:____