1. Are you experiencing ANY of the following emergency symptoms: severe shortness of breath and difficulty breathing, persistent chest pain or pressure, new confusion or inability to arouse, bluish lips or face, loss of consciousness, slurred speech, and/or severe, constant dizziness or lightheadedness?

- [ ] Yes
- [ ] NO

2. Are you experiencing any of the following symptoms? Please select all that apply.

- [ ] Fever, chills or sweating
- [ ] New or worsening cough
- [ ] Fatigue
- [ ] Body aches
- [ ] Diarrhea
- [ ] Reduced sense of small and/or taste
- [ ] Mild to moderate difficulty breathing
- [ ] Sore throat
- [ ] Runny nose
- [ ] None of the above

3. Have you been told by a health official that you may have been exposed to COVID-19 (coronavirus)?

- [ ] Yes
- [ ] NO

4. Have you been around someone who is known to have COVID-19 (coronavirus)?

- [ ] Yes
- [ ] NO

5. Have you been tested before for COVID-19?

- [ ] Yes
- [ ] NO

6. In the last 14 days, have you been in an area of high-risk for COVID-19 (coronavirus)?

- [ ] Yes
- [ ] NO

7. In the last 14 days, have you traveled internationally?

- [ ] Yes
- [ ] NO

8. In the last 14 days, have you traveled on a cruise ship?

- [ ] Yes
- [ ] NO

9. Do you live or work in a care facility? (This includes a hospital, emergency room, other medical setting, or long term facility.)

- [ ] Yes
- [ ] NO

10. Are you currently working in an industry providing critical services that require you to work on location? (This includes industries such as grocery, banking, childcare, etc.)

☐ Yes
☐ NO

11. Over the last 14 days, have you or the people you live with congregated with groups of more than 10 people?

☐ Yes
☐ NO

12. Do you have any of the following? Please select all that apply.

☐ Asthma
☐ Cancer
☐ Diabetes
☐ Heart Disease
☐ High Blood Pressure
☐ Kidney Disease
☐ Liver Disease
☐ Lung Disease