COVID-19 EMPLOYEE QUESTIONAIRE

Name: _____ **Date:** _____

Department: _____

Phone #: _____ **Email:** _____

Symptomatic **Medically advised Quarantine** **Positive Test**
(circle appropriate)

Symptoms: Fever _____ (> 100.4) Chills Sore Throat Fatigue

Headache Muscle pain Shortness of Breath Recent Loss of Taste/Smell

Cough: Dry Productive

GI Issues: Vomiting Diarrhea Nausea

Other Symptoms: _____

Date Symptoms Started:_____

Sought medical attention: YES NO DATE: _____

COVID-19 Test admin: YES NO Results _____ Date of Test _____

Start of Quarantine: _____ **Released from Quarantine:** _____

Have you been exposed to anyone with COVID-19: YES NO

Date of exposure:_____

Have you been exposed to anyone with signs/symptoms: YES NO

Close company contacts: _____ **Dates:** _____

_____

Other personal contacts: _____ **Dates:** _____

_____