Name: DOB: Date of Service:

COVID-19 SCREENING QUESTIONNAIRE		
PLEASE READ EACH QUESTION CAREFULLY	**PLEASE CIRCLE THE ANSWER THAT APPLIES TO YOU**	
Have you had possible exposure to COVID-19 through living or working in a place where people reside, meet, or gather in close proximity (office buildings, schools, healthcare facilities, etc.)?	YES	NO
Do you live or work in close proximity with other people (Schools, Universities, Assisted living facilities, or general workplaces)?	YES	NO
Have you traveled to ANY region or area that has been affected by COVID-19?	YES	NO
Have you had close contact (within 6 feet) with someone who is sick or diagnosed with COVID-19?	YES	NO
Have you experienced any of the following symptoms in the past 48 hours? * Fever or chills * Cough * Shortness of breath or difficulty breathing * Fatigue * Muscle or body aches * Headache * New loss of taste or smell * Sore throat * Congestion or runny nose * Nausea or vomiting * Diarrhea	YES	NO
Is the COVID-19 outbreak causing strong emotions and/or overwhelming anxiety about the possibility of potentially being infected?	YES	NO
Do you have any of the following conditions? Chronic condition (Diabetes, high blood pressure, asthma), Chronic Heart Condition (heart failure, previous heart attack), a condition that weakens your immune system (AIDS, Lupus, cancer, Rheumatoid Arthritis)	YES	NO
Do you use tobacco or nicotine products? (cigarettes, e-cigarettes, vapes, hookah, etc...)	YES	NO
Are you required to provide a COVID-19 test result for return to school or school activities?	YES	NO

Lucid Laboratory Services
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