USATF COVID-19 Symptoms Assessment Questionnaire

NAME:_____ DATE:_____

Please check the appropriate box below

In the past 24 hours, have you experienced:

Fever:

☐ Yes

☐ No

Fatigue:

☐ Yes

☐ No

Cough:

☐ Yes

☐ No

Sneezing:

☐ Yes

☐ No

Aches and Pains:

☐ Yes

☐ No

Runny or Stuffy Nose:

☐ Yes

☐ No

Sore throat:

☐ Yes

☐ No

Diarrhea:

☐ Yes

☐ No

Headaches:

☐ Yes

☐ No

Shortness of breath:

☐ Yes

☐ No

Have you recently been in close contact with anyone who has exhibited any of the above symptoms?

☐ Yes ☐ No

In the last 14 days, have you been in contact with anyone who has tested positive for COVID-19?

☐ Yes ☐ No

Have you traveled within the last 14 days to an international location with widespread ongoing COVID-19 transmission as determined by the CDC (https://www.cdc.gov/coronavirus/2019-ncov/travelers/map-and-travel-notices.html) or have you traveled on a cruise ship or river boat in the last 14 days?

☐ Yes ☐ No