COVID In-Person Risk Questionnaire

8/18/20

Consumer Name: _____ MCO: _____

Date: _____

	Yes	No	Comments
Do you or anyone in your household have symptoms of Coronavirus including fever or chills, cough, sore throat, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, congestion or runny nose, nausea or vomiting, or diarrhea?	☐	☐	Temperature: _____
Have you or anyone in your household traveled in the last 14 days? If so, where?	☐	☐	
Have you or anyone in your household been in close contact with others who have symptoms, are being assessed or monitored for Coronavirus, or who have travelled in the last 14 days?	☐	☐	
Have you or anyone in your household been at a large gathering (as defined by current Governor's Orders of more than 10) in the last 14 days? If yes, please specify the size of the gathering in the comments.	☐	☐	
Have you or someone in your household been tested for COVID-19?	☐	☐	When? _____ Results? Positive ☐ Negative ☐
Are you comfortable having a provider enter your home during the Coronavirus outbreak?	☐	☐	
Notes:			