A WATCHFUL EYE HOMECARE AGENCY, LLC.

Screening Questionnaire – COVID-19 (Coronavirus):

Name: _____

Date: _____

Please circle the appropriate responses.

1. Do you currently have symptoms of a respiratory infection?

☐ NO ☐ YES. – (If so, please indicate your symptoms) Fever Shortness of breath Cough Sore throat Loss of Smell Loss of Appetite.

_____

_____

2. Have you traveled outside this area (surrounding counties) within the past 10 days?

☐ NO ☐ YES – (If YES, When? and Where?)

_____

_____

3. Have you been exposed to someone who has tested positive or diagnosed with COVID-19?

☐ NO ☐ YES – (If YES, When? and Where?)

_____

4. Have you received the Covid-19 vaccination? A. YES- (If YES, When/Date?)

☐ Partial ☐ Complete

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