	Participant Symptom Screening Questionnaire	YES	NO
1.	Have you had any of the following symptoms of COVID-19 within the last 14 days? ▪ Fever or chills ▪ Shortness of breath or difficulty breathing ▪ Cough ▪ Fatigue ▪ New loss of smell or taste ▪ Sore throat ▪ Muscle or body aches ▪ Headache ▪ Congestion or runny nose ▪ Nausea or vomiting ▪ Diarrhea	☐	☐
2.	Has anyone in your household tested positive for COVID-19 within the last 14 days?	☐	☐
3.	Have you had close contact (within 6 feet for 15 or more minutes) with anyone outside your home who has a confirmed COVID-19 diagnosis or COVID-19 symptoms within the last 14 days?	☐	☐
4.	Within the past 14 days, has a public health or medical professional told you to self-monitor, self-isolate, or self-quarantine because of concerns about COVID-19 infection?	☐	☐
5.	Are you currently waiting for the results of a COVID-19 test?	☐	☐

By signing below, I understand the above information regarding COVID-19 and my study visit, and agree that I have answered the Symptom Screening Questionnaire truthfully and to the best of my knowledge.

Name:____

Signature:____

Date:____