



# COMMUNITY BASED HEALTH SCREENING QUESTIONNAIRE

## WELCOME!

We take your health and safety seriously. To help us provide you with the best care, please respond to the following questions. Be assured that your answers will not prevent us from providing you with the service you are seeking, but we may take additional precautions to protect you and others.

**IF YOU ANSWER “YES” TO ANY OF THE FOLLOWING, PLEASE NOTIFY ONE OF OUR STAFF MEMBERS IMMEDIATELY. PLEASE CLEAN YOUR HANDS AND PUT ON A NEW MEDICAL MASK IF YOU HAVE NOT DONE SO ALREADY.**

## IN THE LAST 5 DAYS, HAVE YOU...



**Tested positive or been diagnosed with a viral respiratory illness? (For example: COVID-19, RSV or Influenza?)**

## DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS?



**Difficulty breathing that is new or worse than usual**



**Fever or chills**



**Worsening of a chronic cough**



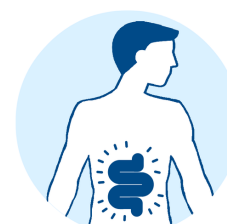
**A new cough**



**Vomiting within the last 48 hours**



**A sore throat**



**New sudden onset of diarrhea**



**A new rash**