COVID-19 Screening Questionnaire

DATE:

FLY/PRP:

PCM:

1. Do you have the following signs and symptoms (check all that apply)?

Fever	Chest Tightness/Pain	Cough
Sore throat	Shortness of breath	Muscle aches
Fatigue	No signs or symptoms	

2. In the past 14 days before symptom onset did you travel to any of the following locations (check all that apply) or have a history of travel to?

A. INDOPACOM

Mainland China	South Korea	Malaysia

B. EUCOM

YES
List:

C. NORTHCOM

YES	
List:	
NO TRAVEL	Cruise Ship Travel

3. In the 14 days before symptom onset, did you have close contact with a person who tested positive for COVID-19?

YES	NO

Personnel Information

Name:	Rank:	
DODID:	DOB:	Unit:
Phone:	Email:	

Travel Location(s) and dates of travel:
Departure Flight Itinerary:
Return Flight Itinerary:

1. If all answers are **NO**, please place “NEGATIVE COVID SCREEN” in the subject line of your email; no further actions are required.
2. If any of the answers are **YES**, please use “COVID SCREEN FOR REVIEW” and public health will be contacting you with further instructions.

****UPON COMPLETION, PLEASE SEND AN ENCRYPTED EMAIL TO trinette.flowerstorres.mil@mail.mil or alan.d.nham.mil@mail.mil or usaf.tinker.72.mdg.mbx-mdg-sgpm-public-health@mail.mil IN PUBLIC HEALTH. ****