COVID-19 Screening Questionnaire

Form updated 04 Jun 20

DATE: **FORM COMPLETED BY:**

FLY/PRP:

PCM:

Personnel Information

Name:		Rank:
DODID:	DOB:	Unit:
Phone:		Email:
Home Address:		Dorm Resident? YES ☐ NO ☐

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

Fever ☐	Cough ☐	Shortness of breath ☐	Repeated shaking w/chills ☐	Loss of taste/smell ☐
Other:		Date of symptom onset:		No signs or symptoms ☐

2. In the past 14 days, did you travel outside of Oklahoma state or have a history of travel?

YES ☐ List:
Dates of travel/Flight Itinerary:
NO TRAVEL ☐

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

YES ☐ NO ☐

****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. ****

Please use "COVID SCREEN FOR REVIEW" and public health will be contacting you with further instructions or information.

CLINIC USE ONLY

Member COVID-19 Tested YES ☐ NO ☐ Quarantine Start date: End date:

If ADSM, list roommates/suite-mate: Full Name: Phone:
PCM:

Full Name: Phone:
PCM:

NOTES:_____