

# 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](mailto:trinette.flowerstorres.mil@mail.mil) or [alan.d.nham.mil@mail.mil](mailto:alan.d.nham.mil@mail.mil) or [usaf.tinker.72.mdg.mbx-mdg-sgpm-public-health@mail.mil](mailto: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 ADASM, list roommates/suite-mate: Full Name: Phone:  
PCM:

Full Name: Phone:  
PCM:

NOTES: \_\_\_\_\_

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