HOWARD UNIVERSITY

Student Health Center
2139 Georgia Avenue, N.W., Suite 201
Washington, DC 20059
Phone (202) 806-7540
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COVID-19 PRE-TEST QUESTIONNAIRE

PATIENT INFORMATION:

Today's date: ____/____/_____

Last Name: _____ **First Name:** _____ **Student ID#: @** _____

Date of Birth: ____/ __ / _____ **Circle Sex: M/ F/ Other** _____ **Race/Ethnicity:** _____

Current Address: _____ **City:** _____ **State:** _____ **ZIP:** _____

Telephone: _____

** **What is your home state:** _____

** **What other states have you visited within the past fourteen (14) days: circle None or list state(s) below:**

_____

CLINICAL SYMPTOMS:

* **HAVE YOU HAD CONTACT WITH SOMEONE WHO HAS TESTED POSITIVE FOR COVID-19: YES ☐ / NO ☐**

* **ARE YOU HAVING ANY OF THE FOLLOWING SYMPTOMS: YES ☐ / NO ☐**

* **EARLIEST SYMPTOM ONSET DATE:** __/__/___

- **FEVER**
- **COUGH**
- **MUSCLE PAIN**
- **HEADACHE**
- **SORE THROAT**
- **SHORTNESS OF BREATH/DIFFICULTY BREATHING**
- **CHILLS**
- **REPEATED SHAKING WITH CHILLS**
- **NEW LOSS OF TASTE OR SMELL**
- **FATIGUE/FEELING TIRED**
- **ALTERED MENTAL STATUS/DISORIENTATED/CONFUSION**
- **GASTROINTESTINAL (e.g. nausea, vomiting, diarrhea)**

Please list any "Pre-existing" medical conditions:

_____

_____

_____

_____

LIVING SITUATION:

- **Dormitory Name & Room Number:** _____
- **Private Home/Apartment /Other:** _____ **Household Number:** _____

ACKNOWLEDGEMENT: BY TAKING THIS COVID-19 TEST AND SIGNING THIS FORM, YOU ACKNOWLEDGE AWARENESS TO SELF- QUARANTINE UNTIL YOU RECEIVE YOUR TEST RESULTS (USUALLY 3-4 DAYS).

Signature: _____ **Date:**_____ **Clinician (RN, MA):** _____