COVID-19 symptom check

1. Do you have any of the following symptoms? (Check all that apply.)
   - ☐ Cough
   - ☐ Difficulty breathing / shortness of breath
   - ☐ Fever
   - ☐ Chills
   - ☐ Repeated shaking with chills
   - ☐ Muscle Pain
   - ☐ Headache
   - ☐ Sore Throat
   - ☐ New loss of taste or smell
   - ☐ Refuse to answer

2. Have you been tested for COVID-19?
   - ☐ Yes
   - ☐ No (skip 1 question)
   - ☐ Refuse to answer (skip 1 question)

3. What was your result?
   - ☐ Negative
   - ☐ Positive
   - ☐ I haven't gotten my result yet
   - ☐ Refuse to answer

4. In the past 2 weeks (14 days), have you been around or spent time with anyone who has tested positive for COVID-19?
   - ☐ Yes
   - ☐ No
   - ☐ Don't know
   - ☐ Refuse to answer

5. Has anyone in your household (besides you) been tested for COVID-19?
   - ☐ Yes
   - ☐ No (skip 1 question)
   - ☐ I live alone (skip 1 question)
   - ☐ Refuse to answer (skip 1 question)

6. Has anyone in your household (besides you) tested positive for COVID-19?
   - ☐ Yes
   - ☐ No
   - ☐ Not sure
   - ☐ Refuse to answer

Contains questions 7-12 from full survey