Visitors Questionnaire to Evaluate Visitor for COVID-19

Company:______________________________

Visitor's Name:______________________________

Address:______________________________

Signature:____________________ **Today's Date**____________________

In the past 24 hours, **have you experienced any of the following symtoms?**

Fever:

- ☐ Yes
- ☐ No

Fatigue:

- ☐ Yes
- ☐ No

Cough:

- ☐ Yes
- ☐ No

Sneezing:

- ☐ Yes
- ☐ No

Aches and Pains:

- ☐ Yes
- ☐ No

Runny or Stuffy Nose:

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- ☐ Yes
- ☐ No

Sore throat:

- ☐ Yes
- ☐ No

Diarrhea:

- ☐ Yes
- ☐ No

Headaches:

- ☐ Yes
- ☐ No

Shortness of breath:

- ☐ Yes
- ☐ No

Have you recently been in close contact with anyone who has exhibited any symptoms?

- ☐ Yes
- ☐ No

Have you recently been in contact with anyone who has tested positive for COVID-19?

- ☐ Yes
- ☐ No

Have you recently traveled to a restricted area that is under a Level 2, 3, or 4 Travel Advisory according to the U.S. State Department? Including: China, Italy, Iran, and most countries in Europe.

- ☐ Yes
- ☐ No

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