Coronavirus (COVID-19)
FBIC Health Screening Questionnaire
(available at www.fbicdetroit.org)

Name ____ Date ___________

Phone Number ____________________ Time ________

Have you received the COVID-19 Vaccine? ( ) Yes ( ) No
If yes, ( ) Injection #1 ( ) Both Injections #1 & #2
In the past 24 hours, have you experienced

Fever	**( ) Yes**	**( ) No**
New or worsening cough.	**( ) Yes**	**( ) No**
Shortness of breath	**( ) Yes**	**( ) No**
Sore throat	**( ) Yes**	**( ) No**
Diarrhea	**( ) Yes**	**( ) No**
Current Temperature		

If you answered "yes" to any of the symptoms listed above, or your temperature is **100.4** degrees or higher please self isolate at home and contact your primary care physician for directions.
In the past 14 days have you:

Had close contact with an individual diagnosed with COVID-19?
( ) Yes ( ) No

Traveled internationally or domestically? ( ) Yes. ( ) No **If you answered "yes " to either of these questions please leave FBIC and we recommend quarantine at home for 14 days.**