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