1) Gender ____________

2) Ethnicity ___________

3) Birthdate __________

4) Zip Code ___________

5) Have you experienced any symptoms? YES NO

6) What Symptoms? A) Fever > 100.4F (18C) B) Subjective Fever(feverish) C) Chills D) Muscle Aches

   E) Runny Nose F) sore throat G) Cough H) Shortness of Breath I) Nausea J) Headache K) Abdominal Pain

   L) Diarrhea M) Persistent Chest Pain N) Inability to Arouse O) New Confusion P) Blush Lips or Face

   Q) Other _________________________

7) Have you had exposure to anyone with Covid 19 Symptoms? YES NO

8) Have you been to see a physician? YES NO

9) Were you tested for Coronavirus? YES NO

10) Are you a current smoker? YES NO

11) Do you have any of these pre-existing medical conditions? A) Chronic Lung Disease B) Diabetes

    C) Cardiovascular Disease D) Chronic Renal Disease F) Chronic Liver Disease

    G) Immunocompromised condition H)Neurological/Neurodevelopmental I) Other _______________

12) Have you had the Flu Shot? YES NO

13) How many people live in your household? _______________

14) What are their ages? __________________________________

15) Are you able to stay home? YES NO