**RESEARCH SUBJECT PHONE SCREENING SURVEY**

**NAME of Participant**/person providing information:­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­\_\_

**DOB** of research subject:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DATE** of survey completion:\_\_\_\_\_\_\_\_\_\_\_\_\_

Study Name/Identifier:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Have you been in contact with anyone suspected or known to have Coronavirus or to anyone who is in quarantine?
  + YES or NO
* Have you traveled outside of the U.S. within the last 21 days?
  + YES or NO
* Have you been to New York, California, or Washington in the past 21 days?
  + YES or NO
* Have you had a fever (>100.4°F) within the last 21 days?
  + YES or NO
* Are you currently having any of the following symptoms? (Circle):
* Cough
* Shortness of breath
* Sore throat
* Malaise (*feeling poorly*)
* Chills
* Pneumonia
* Altered Mental Status
* Vomiting
* Severe headache
* Muscle aches

**Recommendation:** if individual response yes to any of the questions, it is recommended that participant be refused and contacted at a later time for rescreening/enrollment.

Printed name of person conducting survey:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Comments/disposition:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_