KINGSTON
HEALTHCARE COMPANY

Visitor/Vendor Health Screening Questionnaire

Visitor Name: _____ **Today's Date:** _____

Address: _____ **Contact Number:** _____

Name of Resident you are here to visit: _____

Current Temperature: _____ **ID Checked:** _____ **By:** _____

1. In the last 14 days have you traveled of the state other than to your home? Yes____ No_____

   If Yes, where did you travel? _____

2. In the last 14 days have either you or a household member tested positive for COVID-19 or been exposed to anyone with a confirmed case of COVID-19? Yes_____ No_____

3. Have you had any of the following symptoms in the last 14 days?

Fever of 100.0 or greater	Yes_____ No_____
Cough	Yes_____ No_____
Shortness of breath	Yes_____ No_____
Sore throat	Yes_____ No_____
Runny nose	Yes_____ No_____
Fatigue	Yes_____ No_____
Malaise	Yes_____ No_____
Body aches	Yes_____ No_____
Diarrhea	Yes_____ No_____
New loss of taste or smell	Yes_____ No_____
Muscle pain	Yes_____ No_____
Headache	Yes_____ No_____
Chills	Yes_____ No_____
Repeated shaking with chills	Yes_____ No_____
Nausea	Yes_____ No_____
Vomiting	Yes_____ No_____

UPDATED: 8.3.2020