Village of Hoffman Estates Health and Human Services
Screening Questionnaire for COVID-19

The safety of our community members is very important to us. As the coronavirus disease 2019 (COVID-19) outbreak continues to evolve and spread globally, the Village of Hoffman Estates is monitoring the situation closely and will continually update guidance based on current recommendations from the CDC and the WHO. To prevent the spread of COVID-19 and reduce the potential risk of exposure to those attending our clinics or receiving services, we are conducting a simple screening questionnaire. Your participation is important to help us take precautionary measures to protect you and your family.

Please complete the areas in blue. Answer the four questions then sign and date.
Return this form with your Eligibility Form and Immunization Records by emailing to:
hhs@hoffmanestates.org or fax to: 847-781-4869.

Name(s): _____Appointment Date: ___/___/2020 Time: _____

Car Make: _____ Car Model: _____ Color: _____

1	In the past 14 days, have you or anyone in your household been diagnosed with COVID-19, experienced any cold or flu-like symptoms, respiratory illness or have you been around people who are sick? □ Fever □ Cough □ Sore throat □ Difficulty breathing/Shortness of breath Please Explain: _____
2	Have you or anyone in your household experienced any of the following in the past 14 days? □ Chills or repeated shaking with chills □ Muscle pain □ Headache □ Sore throat □ Loss of taste or smell □ Nausea/Vomiting □ Diarrhea Please Explain: _____
3	Have you or anyone in your household experienced any other new or concerning symptoms (rashes, red, purple or swollen toes/fingers, or pink eye): Yes □ No □ Please Explain: _____
4	Have you or anyone in your household had close contact with or cared for someone diagnosed with COVID-19 within the last 14 days? Yes □ No □

Client Signature: _____ Date: _____

Message for Client: If you or any member of your household have marked yes to any question, is experiencing any symptoms or concerns in the past 14 days, or has a temperature of 100.4° F or higher, we ask you to please postpone your visit for at least 14 days. We are happy to reschedule your appointment. Please contact your healthcare provider if your symptoms get worse. Thank you for your understanding. For more information, please visit www.cdc.gov/coronavirus

For Office Use Only:
Phone Screening: Date: _____ Status: _____Signature_____
Phone Screening: Date: _____ Status: _____Signature_____
Comments:_____
****
Clinic Day Screening: Status: _____ Temperature: Adult _____ ° F Child _____° F (Infrared Forehead)
Comments: _____
Screening Coordinator/Date: _____