Form Approved
OMB Control No.0920-XXXX
Exp XX/XX/XXXX

COVID-2019 SUPPLEMENTAL QUESTIONNAIRE

Providing the following information to the Centers for Disease Control and Prevention is required under Title 42 Code of Federal Regulations Section 71.20, and is being collected as part of the public health response to a new coronavirus (COVID-2019) first identified in China. The information will be used by U.S. public health authorities and other international, federal, state, or local agencies for public health purposes.

Instructions for CDC Quarantine Station Staff

- *If there is a possibility of COVID-2019 infection, use this form during tertiary screening to collect additional information not captured by the Travelers' Health Declaration form, CDC Air Illness or Death Investigation form or when conducting illness response for respiratory illness. Travelers should not complete the form.*
- *For anyone with a fever or an acute lower respiratory illness who answers YES to #1-2, have a low threshold to refer for isolation and medical evaluation, especially if the person was a health care worker or household caregiver. If you are unsure, consult the CDC EOC PUI Team and your state/local health department.*
- *If referring for isolation and medical evaluation, provide the information collected to the health department and the health care facility. Enter the information collected into the QARS record.*

IN THE PAST 14 DAYS

1. Have you visited, worked in or been hospitalized in any health care facility in China or Iran? **YES ___ NO___**
   a) City where facility is located: _____
   b) Date of last visit or discharge: ____/____/____ (Day/Month/Year)

2. Have you had contact with a person known to be infected with the Novel Coronavirus (COVID-2019)? **YES ___ NO___**

3. If yes to #2
   a) What was your relationship to the person(s) (friend, colleague, family member, spouse)? _____
   b) Did you have close contact (within 6 feet/2 meters)? **YES ___ NO___**
   c) Did you provide care to the person? **YES ___ NO___**
      i. If yes, where? Check one: Home _____ Health care facility _____

SINCE DECEMBER 1, 2019

4. Have you been diagnosed with COVID-2019 infection? **YES ___ NO___**

5. If yes, when were you diagnosed? ____/____/____(Day/Month/Year)

   [*Collect additional information on course of illness. If any concern that diagnosis is related to current illness (e.g., symptoms never fully resolved), consult health department and PUI Team.*]

COVID-2019 SUPPLEMENTAL QUESTIONNAIRE