APPENDIX A: <u>COVID-19 Screening Questions</u>

In the last 14 days, have you had:

Fever or chills	**____Yes**	**____No**	
Cough	**____Yes**	**____No**	
Shortness of Breath or difficulty breathing	**____Yes**	**____No**	
Nausea or vomiting	**____Yes**	**____No**	
Fatigue	**____Yes**	**____No**	
Muscle or body aches	**____Yes**	**____No**	
Headache	**____Yes**	**____No**	
Sore Throat	**____Yes**	**____No**	
Loss of taste of smell	**____Yes**	**____No**	
Diarrhea	**____Yes**	**____No**	
Congestion or runny nose	**____Yes**	**____No**	
Have you had contact with known or presumed COVID-19 patient in the last 14 days?	**____Yes**	**____No**	
Have you traveled outside the state of Pennsylvania in the last 14 days?	**____Yes**	**____No**	
If yes, have you quarantined for 14 days or received a negative covid-19 test in the last 72 hours?	**____Yes**	**____No**	
If you are traveling from a another state other than Pennsylvania have you quarantine for 14 days or received a negative covid-19 test within the last 72 hours?	**____Yes**	**____No**	**____N/A**

If the subject answers Yes to any of the above questions, please cancel your MRI and do not come to the MRRC.