University of California
San Francisco

# Infectious Disease – Coronavirus Symptom Self-Monitoring Form

Occupational Health Services

## EMPLOYEE DETAILS

| | |
|---|---|
| Name:<br>Date of Birth: | Position:<br>Visitor (Yes / No) |
| Employee ID:<br>Department: | Contact Telephone#: ( ) Email: |

## SIGNS & SYMPTOMS

- Please complete each line of the symptom columns, twice a day until the self-monitoring end date is reached. Temperature must be assessed twice a day.
- If new symptoms arise, consult with your primary care provider for care as needed and call the UCSF COVID Hotline (415.514.7328) for triage, testing recommendations, or return to work guidance.
- At the end of your 14 day self-monitoring period, please return the completed, signed form via fax or secure email:
  - Confidential fax: 415.514.5614
  - Email: ohs@ucsf.edu. Please write Secure: in the subject line.

| Date/Time | Temperature (twice daily) | Cough | Sore Throat | Shortness of breath or difficulty breathing | Unexplained muscle aches | Loss of smell or taste | Nasal congestion | Diarrhea | Eye redness+/- discharge | Myalgia / Malaise | Headache | Rash | Unexplained Bleeding/ Bruising | Comments |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | (√) | (√) | (√) | (√) | (√) | (√) | (√) | (√) | (√) | (√) | (√) | (√) | |
| | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | |

Signature: _____ Date: _____