COVID SCREENING QUESTIONNAIRE

Please complete the questionnaire and bring to your appointment.

Patient Name:_____ Date:_____

Screening Questions:	**YES**	**NO**
1. Have you travelled outside of Canada in the past 14 days?	☐	☐
2. Have you tested positive for COVID-19 or had close contact with a confirmed case of COVID-19 without wearing appropriate PPE?	☐	☐
3. Do you have any of the following symptoms?		
• Fever	☐	☐
• New onset of cough	☐	☐
• Worsening chronic cough	☐	☐
• Shortness of breath	☐	☐
• Difficulty breathing	☐	☐
• Sore throat	☐	☐
• Difficulty swallowing	☐	☐
• Decrease or loss of sense of taste or smell	☐	☐
• Chills	☐	☐
• Headaches	☐	☐
• Unexplained fatigue/malaise/muscle aches	☐	☐
• Nausea/vomiting/diarrhea, abdominal pain	☐	☐
• Pink eye (conjunctivitis)	☐	☐
• Runny nose or nasal congestion without other known cause	☐	☐

If 70 years of age or older, are you experiencing any of the following symptoms?

• Delirium	☐	☐
• Unexplained or increased number of falls	☐	☐
• Acute functional decline	☐	☐
• Worsening of chronic conditions	☐	☐