



Covid-19 Screening Questionnaire

Temperature:

Please answer the following questions to the best of your knowledge:

Yes No

1. In the LAST 14 days, have you or do you have:

• Flu-like symptoms?		
• Shortness of Breath or Difficulty Breathing		
• New onset of Cough or Worsening chronic cough.		
• Difficulty Swallowing		
• Fever		
• Chills		
• Headaches		
• Sore throat		
• Decrease or loss of sense of taste or smell		
• Unexplained fatigue/malaise/muscle aches (myalgias)		
• Nausea/vomiting, diarrhea, abdominal pain		
• Pink eye (conjunctivitis)		
• Runny nose/nasal congestion without other known cause		
2. Are you awaiting results of a lab test for COVID-19?		
3. Have you tested positive for COVID-19? When?		
4. Have you or a family member previously been asked to self-isolate or self-quarantine in the past 14 days?		
5. Have you had close contact to an individual diagnosed with COVID-19 infection in the past 14 days without wearing appropriate PPE?		
6. Have you travelled in the past 14 days outside of Canada?		

Patient Full Name:

Date of Birth:

Patient Signature:

Date: