COVID SCREENING QUESTIONNAIRE

Patient Name: _____
Date of Birth: _____
Temperature: _____ Log Time: _____
Date of Exam: _____

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 within the last 14 days?	☐	☐
3. Do you have a fever, new onset of coughing or new onset of breathing difficulty/shortness of breath? (Does not apply if negative COVID test within 14 days).	☐	☐
4. Do you have any of the following symptoms?	**YES**	**NO**
Worsening chronic cough	☐	☐
Worsening shortness of breath	☐	☐
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?	**YES**	**NO**
Delirium	☐	☐
Acute functional decline	☐	☐
Unexplained or increased number of falls	☐	☐
Worsening of chronic conditions	☐	☐
5. Do you live and/or work in an assisted living, group/retirement home, healthcare facility? Outbreak Y ☐ N ☐	☐	☐