COVID-19 Patient Screening Form

Patient Information

First Name: _____ **Last Name**: _____ **DOB** ____/_____/_____ (M/D/Y)

Address: _____ **Postal Code:** _____

Phone #: (_____) _____ **Email**: _____

Questionnaire	
1. Have you travelled outside of Canada in the last 14 days (circle answer)?	**YES** or **NO**
2. Has someone you are in close contact with tested positive for COVID-19 in the last 14 days?	**YES** or **NO**
3. Have you previously tested positive for COVID-19?	**YES** or **NO**
4. Are you in close contact with a person who is sick with new respiratory symptoms or who recently traveled outside of Canada?	**YES** or **NO**
5. Do you have any of the following symptoms? (circle answer)	
• Fever	**YES** or **NO**
T^{o} _____ (Front desk staff will take your temperature)	
• Chills	**YES** or **NO**
• New or worsening cough (dry or productive)	**YES** or **NO**
• Shortness of breath/difficulty breathing	**YES** or **NO**
• Sore throat	**YES** or **NO**
• Difficulty swallowing	**YES** or **NO**
• Loss of taste or smell	**YES** or **NO**
• Pink eye (conjunctivitis)	**YES** or **NO**
• Headache that is unusual or long-lasting	**YES** or **NO**
• Runny or stuffy nose (not related to seasonal allergies or other known causes or conditions)	**YES** or **NO**
• Nausea/vomiting/diarrhea/abdominal pain	**YES** or **NO**
• Muscle aches	**YES** or **NO**
• Unexplained fatigue/malaise	**YES** or **NO**

I confirm that the information above is correct to the best of my knowledge.

Patient Signature: _____ Date: _____/_____/2021