COVID-19 Screening Questionnaire

Please check all that apply

Do you have <u>new or worsening</u> of any of the following symptoms:	Yes	No
• Fever >38°C or think you have a fever or chills	☐	☐
• Cough	☐	☐
• Sore throat/hoarse voice	☐	☐
• Shortness of breath/breathing difficulties	☐	☐
• Loss of taste or smell	☐	☐
• Vomiting or diarrhea for more than 24 hours	☐	☐
• Runny nose	☐	☐
• Muscle aches	☐	☐
• Fatigue	☐	☐
• Pink eye	☐	☐
• Headache	☐	☐
• Skin rash of unknown cause	☐	☐
• Nausea or loss of appetite	☐	☐
Exposure history	**Yes**	**No**
Have you been in close contact in the last 14 days with a confirmed COVID-19 case?	☐	☐
Have you been exposed to COVID-19 in a work or public setting?	☐	☐
Have you travelled outside of Ontario or Canada in the past 14 days?	☐	☐
In the last 14 days has anyone living in your household travelled outside of Canada. If YES, continue to questions A. If NO, do not complete A or B.	☐	☐
A. If YES to the above question, is your household traveller exempt from self-isolation requirements? If no, continue to question B. If yes, do not complete B.	☐	☐
B. If NO to A, have you been in close contact with the household traveller in the last 14 days since their return from travel?	☐	☐

Patient Name Date