Covid-19 Screening Questions

Please circle Yes or No

Thank you for providing the following information, this page will be attached to your confidential health history file.

1) Have you had any close contact with anyone with acute respiratory illness (difficulty breathing) or travelled outside of Ontario in the past 14 days?

   Yes / No

2) Have you tested positive for COVID-19 or had had close contact with a confirmed case of COVID-19? Yes / No

3) Do you have the any of the following symptoms:

   - Fever Yes / No
   - New cough Yes / No
   - Worsening of chronic cough Yes / No
   - Shortness of breath Yes / No
   - Difficulty breathing Yes / No
   - Sore throat Yes / No
   - Difficulty swallowing Yes / No
   - Decrease or loss of sense of taste or smell Yes / No
   - Chills Yes / No
   - Headaches Yes / No
   - Unexplained fatigue/muscle aches/malaise Yes / No
   - Nausea/ vomiting/ diarrhea, abdominal pain Yes / No
   - Pink eye (conjunctivitis) Yes / No
   - Runny nose/nasal congestion unknown cause Yes / No

4) If you are 70 years of age or older, are you experiencing any following symptoms : delirium, unexplained or increased falls, acute functional decline or worsening of chronic conditions? Yes / No / N/A

Client Signature: _____ Date:_____