# Patient Screening Form

| Screening Questions | Pre-Screen | |
|---|---|---|
| **Do you have a fever or have felt hot or feverish anytime in the last two weeks?**<br>**Patient temperature at appointment:**<br>**If elevated, provide mask to patient.** | **Yes** ☐ | **No** ☐ |
| **Do you have dry cough?** | **Yes** ☐ | **No** ☐ |
| **Do you have shortness of breath? Difficulty breathing?** | **Yes** ☐ | **No** ☐ |
| **Do you have sore throat?** | **Yes** ☐ | **No** ☐ |
| **Do you have runny nose?** | **Yes** ☐ | **No** ☐ |
| **Have you experienced a recent loss of smell or taste?** | **Yes** ☐ | **No** ☐ |
| **Have you been in contact with any confirmed COVID-19 positive patients ,or persons isolating because of a determined risk for COVID-19?** | **Yes** ☐ | **No** ☐ |
| **Have you returned from travel outside of Canada in the last 14 days?** | **Yes** ☐ | **No** ☐ |
| **Have you returned from travel within Canada from a location known affected with COVID-19?** | **Yes** ☐ | **No** ☐ |
| **Are you over the age of 60?** | **Yes** ☐ | **No** ☐ |

# Patient Screening Form

| Screen Questions | Pre-Screen | |
|---|---|---|
| Do you have Heart disease/ lung disease/ kidney disease? | Yes ☐ | No ☐ |
| Do you have diabetes? | Yes ☐ | No ☐ |
| Do you have any auto-immune disorder? | Yes ☐ | No ☐ |
| Do you have nasal congestion/ hoarse voice? | Yes ☐ | No ☐ |
| Do you have difficulty swallowing? | Yes ☐ | No ☐ |
| Do you have chills? | Yes ☐ | No ☐ |
| Do you have headaches? | Yes ☐ | No ☐ |
| Do you have unexplained fatigue/ malaise | Yes ☐ | No ☐ |
| Do you have diarrhea? | Yes ☐ | No ☐ |
| Do you have abdominal pain? | Yes ☐ | No ☐ |
| Do you have nausea/ vomiting? | Yes ☐ | No ☐ |