Name | Age | Date of Appointment

COVID-19 PATIENT SCREENING
Dr. M. Tanen

Background Question

1. ☐ **YES** ☐ **NO** Did you receive your final (or second) vaccination dose more than 14 days ago?

Screening Questions

2. ☐ **YES** ☐ **NO** Do you have any of the following symptoms?

- Fever and/or chills
- New onset of cough or worsening chronic cough
- Shortness of breath
- Decrease or loss of sense of taste or smell
- If adult 18 years of age or older: Unexplained fatigue / lethargy / malaise / muscle aches (myalgias)
- If child under 18 years of age: Nausea / vomiting, diarrhea

3. ☐ **YES** ☐ **NO** Have you tested positive for COVID-19 in the past 10 days or have you been told you should be isolating?

Continue to questions 4 and 5 only if you are NOT fully immunized (i.e., you answered "NO" to Question 1 above):

4. ☐ **YES** ☐ **NO** Have you travelled out of Canada in the past 14 days?

5. ☐ **YES** ☐ **NO** Have you had close contact with a confirmed case of COVID-19 without wearing appropriate PPE?

Office use:

Forehead temperature _____°C

Notes:

Ver. 9.21