Name | | Date of Appointment | |

COVID-19 PATIENT SCREENING
Dr. M. Tanen

1. ☐ **YES** ☐ **NO** Are you fully vaccinated against COVID-19 and/or aged 11 or under?

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

- Severe difficulty breathing
- Severe chest pain
- Feeling confused or unsure where you are
- Losing conciousness

3. ☐ **YES** ☐ **NO** In the past 14 days have you been directed by a federal border agent to comply with federal quarantine requirements due to international travel?

4. ☐ **YES** ☐ **NO** In the last 5 days have you experienced any of these symptoms?

- Fever and/or chills
- Coughing or barking cough (croup)
- Shortness of breath
- Decrease or loss of taste or smell
- Muscle aches/joint pain
- Extreme tiredness
- Sore throat
- Runny or stuffy/congested nose
- Headache
- Nausea or vomiting and/or diarrhea

5. ☐ **YES** ☐ **NO** Do any of the following apply:

- You live with someone who is currently isolating because of a positive COVID-19 test
- You live with someone who is currently isolating because of COVID-19 symptoms
- You live with someone who is isolating while waiting for COVID-19 test results

Select "No" if you

- are 18 or older and have received your booster dose, **or**
- are 17 or younger and are fully vaccinated, **or**
- completed your isolation after testing positive in the last 90 days (using a rapid antigen, rapid molecular, or PCR test)

6. ☐ **YES** ☐ **NO** In the last 5 days, have you tested positive on a rapid antigen test, molecular test, or home-based self-testing kit?

Select “No” if you have already completed your isolation period of 10 days because your symptoms started before your positive test result, **and** you do not have a fever, **and** your symptoms have been improving for 24 hours (48 hours for nausea, vomiting, and/or diarrhea)

7. ☐ **YES** ☐ **NO** Has a doctor, health care provider, or public health unit told you that you should currently be isolating (staying at home)?