COVID-19 Screening Questionnaire

		Yes	No
Do you have any of the following possible symptoms related to COVID-19 ?	**Fever or chills**		
	Cough or worsening chronic cough		
	Difficulty breathing		
	Flu like symptoms (headache, sore throat, runny nose)		
	Unusual muscle or body aches		
	Atypical headache		
	New loss of taste or smell		
	Nausea or vomiting		
	Diarrhea		
Have you travelled outside of Canada in the last 14 days for any reason besides essential workers using PPE?			
Have you been in contact with someone who is a confirmed case of COVID-19 in the last 14 days ?			
Have you been advised by your physician or Public Health professional to be in self-isolation (currently or within the last 14 days)?			

Name & Date: _____ Phone Number: _____

Address & email: _____