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?		○	○
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)?		○	○