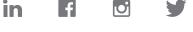
COVID-19 Screening Questionnaire

		Yes	Νο
Do you have any of the following possible symptoms related to COVID-19?	Fever or chills	0	0
	Cough or worsening chronic cough	0	0
	Difficulty breathing	0	0
	Flu like symptoms (headache, sore throat, runny nose)	0	0
	Unusual muscle or body aches	0	0
	Atypical headache	0	0
	New loss of taste or smell	0	0
	Nausea or vomiting	0	0
	Diarrhea	0	0
Have you travelled outside of Canada in the last 14 days?		0	0
Have you been in contact with someone who is a confirmed case of covid-19 in the last 14 days?		0	0
Have you been advised by your physician or Public Health professional to be in self-isolation (currently or within the last 14 days)?		0	0





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