COVID-19 Pre-screening Form

To help our clinical team provide a safe environment for patients and staff, please complete this questionnaire prior to your appointment. If you answer 'Yes" to any of the questions, please contact our office before your appointment date for further consultation.

1. Have you had **COVID-19** in the past 14 days?

   Yes ☐ No ☐

2. Are you under order to **quarantine** after travel outside Canada?

   Yes ☐ No ☐

3. Been told to **self monitor** or **self isolate** by public health following a close contact exposure to COVID-19?

   Yes ☐ No ☐

4. Had a **COVID test** within the last 14 days or recommended to get a test?

   Yes ☐ No ☐

5. Do you have any of the following symptoms

   ☐Fever or chills? ☐Difficulty breathing?

   ☐Cough? ☐Loss of small or taste?

   ☐Sore throat?

6. Do you have 2 or more of the following symptoms in the last 24 hours

   ☐Extreme fatigue or tiredness? ☐Loss of appetite

   ☐Body aches? ☐Headaches

   ☐Diarrhea ☐Nausea or vomiting