

# COVID-19 Screening Questionnaire

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