



Client Name: _____

Date Visited/Trained: _____

COVID 19 - Screening Questions

Did you travel outside of Canada in the past 14 days?

Yes No

Have you tested positive for COVID-19 or had close contact with a confirmed case of COVID-19 without wearing appropriate PPE?

Yes No

Do you have any of the following symptoms?

Yes No

- Fever
 - New onset of cough
 - Worsening chronic cough
 - Shortness of breath
 - Difficulty breathing
 - Sore throat
 - Difficulty swallowing
 - Decrease of loss of sense of taste or smell
 - Chills
 - Headaches
 - Unexplained fatigue/malaise/muscle aches (myalgias)
 - Nausea/vomiting, diarrhea, abdominal pain
 - Pink eye (conjunctivitis)
 - Runny nose or nasal congestion without other known cause
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If you are 70 years of age or older, are you experiencing any of the following symptoms?

Yes No

- Delirium
- Unexplained or increased number of falls
- Acute functional decline
- Worsening of chronic conditions