Regular Screening Questions

Please read each of these questions and if you can say no to all these questions, then we can proceed with treatment.

Q2: Did you have close contact with anyone with acute respiratory Illness or travelled outside of Ontario in the past 14 days?

Q3: Do you have a confirmed case of COVID-19 or had close contact with a confirmed case of COVID-19?

Q4: Do you have any of the following symptoms:
•Fever
•New onset of cough
•Worsening chronic cough
•Shortness of breath
•Difficulty breathing
•Sore throat
•Difficulty swallowing
•Decrease or 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/nasal congestion without other known cause

Q5: If you are 70 years of age or older, are you experiencing any of the following symptoms: delirium, unexplained or increased number of falls, acute functional decline, or worsening of chronic conditions?

I say no to the above questions.

Signed:

_____

Name Date