**COVID-19: SCREENING QUESTIONNAIRE**

Patient name: _____ Email: _____

Phone number: _____

Have you travelled 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?

Yes ☐ No ☐

I confirm that I am not presenting any of the following symptoms of COVID-19 identified by Public Health Services: _____ (Initial)

- 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

What is your COVID vaccination status?

☐ None taken
☐ Single dose
☐ Two doses
☐ Booster dose taken

Which vaccination did you take?

☐ Pfizer
☐ Moderna
☐ Astra Zeneca
☐ Other, please specify (including mixed vaccines) _____

Age: Below 70 ☐ Above 70 ☐

**Ask if the person is 70 years of age or older**

Are you experiencing any of the following symptoms?

- Delirium Yes ☐ No ☐
- Unexplained or increased number of falls Yes ☐ No ☐
- Acute functional decline Yes ☐ No ☐
- Worsening of chronic conditions Yes ☐ No ☐

| **If response to ALL of the screening questions is NO:** |
| --- |
| **COVID Screen Negative** |

| **If response to ANY of the screening questions is YES:** |
| --- |
| **COVID Screen Positive** |

I verify the information I have provided on this form is truthful and accurate. I knowingly and willingly consent to have dental treatment completed.

Patient/Parent/Guardian Signature *

Date*