

COVID-19 Screening Questionnaire

Patient Name:

	PRE-APPOINTMENT	IN-OFFICE
	Date:	Date:
Do you have a fever or have you felt hot or feverish recently (past 14-21 days)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you having shortness of breath or other difficulties breathing?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have a cough?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you experienced recent loss of taste or smell?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you been in contact with any confirmed COVID-19 positive patients? <i>Patients who are well but have a sick family member at home with COVID-19 should postpone elective treatment.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you traveled out of British Columbia in the past 14 days?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

If you answer "yes" to any of the above questions, speak to a member of our clinical staff prior to your appointment and delay elective treatment for 14 days. If you are over the age of 70, or have heart disease, lung disease, kidney disease, uncontrolled diabetes, or autoimmune disorders, you are at significantly increased risk of complications if you contract COVID-19.