COVID-19 SCREENING QUESTIONNAIRE

Patient Name:________________________________ Date:________________

		YES	NO	N/A
QUESTION ONE	Have you had close contact with anyone with acute respiratory illness or travelled outside of Ontario in the past 14 days?	☐	☐	
QUESTION TWO	Do you have a confirmed case of Covid-19 of had close contact with a confirmed case of Covid-19?	☐	☐	
QUESTION THREE	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 of smell	☐	☐	
	○ Chills	☐	☐	
	○ Headaches	☐	☐	
	○ Unexplained fatigue/malaise/muscle aches (myalgias)	☐	☐	
	○ Nausea/vomiting, diarrhea, abdominal cramps (of unknown origin)	☐	☐	
	○ Pink eye (conjunctivitis)	☐	☐	
	○ Runny nose/nasal congestion without other known cause	☐	☐	
QUESTION FOUR	If you are over the age of 70, are you experiencing any of the following symptoms:			
	• Delirium	☐	☐	☐
	• Unexplained or increased number of falls	☐	☐	☐
	• Acute functional decline	☐	☐	☐
	• Worsening of chronic conditions	☐	☐	☐

I verify the information I have provided on this form is truthful and accurate. I knowingly and willingly consent to have dental treatment completed today during the COVID-19 pandemic.

Patient (Guardian) Signature: ____