Patient Screening Form

Please complete and bring signed form to your scheduled appointment.

Patient Name: _____ **Date of Birth:** _____

Address:

Street: _____ Apt#: _____ City: _____

Province: _____ Postal Code: _____

	Yes	No
1. Do you have a fever or have felt hot or feverish anytime in the last two weeks?	◯	◯
2. Do you have any of these symptoms: Dry cough? Shortness of breath? Difficulty breathing? Sore throat? Runny nose? Sneezing? Post-nasal drip?	◯	◯
3. Have you experienced a recent loss of smell or taste?	◯	◯
4. Have you been in contact with any confirmed COVID-19 positive patients, or persons self-isolating because of a determined risk for COVID-19?	◯	◯
5. Have you returned from travel outside of Canada in the last 14 days?	◯	◯
6. Have you returned from travel within Canada from a location known affected with COVID-19?	◯	◯
8. Are you over the age of 70?	◯	◯
9. Do you have any of the following: Heart disease, lung disease, kidney disease, diabetes or any auto-immune disorder	◯	◯

Patient Signature: _____ **Date Signed:** _____

Office Contact Information:

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