



PRIMARY CARE HEALTH SCREENING QUESTIONNAIRE

WELCOME TO THE CLINIC!

We take your health and safety seriously. To help us provide you with the best care, please respond to the following questions. Be assured that your answers will not prevent us from providing you with the service you are seeking, but we may take additional precautions to protect you and others.

CHECK THE BOX IF IN THE LAST 14 DAYS YOU HAVE...

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Been ordered to quarantine after travel outside of Canada

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Been told to self-isolate by Public Health following a Covid-19 close contact exposure

☐

Had a COVID-19 test or been told to have a COVID-19 test by a health professional

CHECK THE BOX IF YOU HAVE ANY OF THE FOLLOWING SYMPTOMS...

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Loss of sense of smell or taste

☐

Fever or chills

☐

A new cough

☐

A worsening of your chronic cough

☐

Difficulty breathing that is new or worse than usual

☐

Vomiting within the last 48 hours

☐

A new rash

☐

A sore throat

IF YOU ANSWERED "YES" TO ANY OF THE ABOVE, PLEASE NOTIFY ONE OF OUR STAFF MEMBERS IMMEDIATELY.