Dr. Nicolaas van As, Family Physician

Temporary Office: 348 Lyndoch St. Corunna, ON N0N 1G0
Telephone 519 813 9196
Fax 855 941 4641

COVID-19 Screening Questionnaire

Name: _____

Do you have a concern that you or someone in your household may have COVID-19?

☐ Yes ☐ No

Have you or anyone in your household travelled outside of Canada in the last 14 days?

☐ Yes ☐ No

Have you tested positive for COVID-19 or been in close contact with someone with a confirmed case of COVID-19 without wearing appropriate personal protective equipment?

☐ Yes ☐ No

Do you have any of the following symptoms?

- ☐ **No Symptoms**
- ☐ Fever
- ☐ New onset of cough
- ☐ Worsening chronic cough
- ☐ Shortness of breath
- ☐ Difficulty breathing
- ☐ Sore throat
- ☐ Difficulty swallowing
- ☐ Decease/loss of sense of taste or smell
- ☐ Chills
- ☐ Headache
- ☐ Unexplained fatigue/malaise
- ☐ Muscle aches
- ☐ Nausea/vomiting
- ☐ Diarrhea/Abdominal Pain
- ☐ Pink eye (conjunctivitis)
- ☐ Runny nose or nasal congestion without other known cause

If you are age 65+, are you experiencing any of the following?

- ☐ **Not Applicable**
- ☐ Delirium
- ☐ Unexplained or increased number of falls
- ☐ **No Symptoms**
- ☐ Acute functional decline
- ☐ Worsening of chronic conditions

Patient Signature: _____ Date: _____

**** If you answered "Yes" to ANY of the questions or have ANY of the mentioned symptoms DO NOT come to the office. Call the office for further instructions.**