Dr \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

COVID-19 Patient Questions

|  |  |
| --- | --- |
| **Date:** | **File No.:** |
| **First Name:** | **Last Name:** |
| **Cell:** | **Temperature:** |
| **Email:** | |

|  |  |  |
| --- | --- | --- |
|  | **PRE-APPOINTMENT** | **IN OFFICE** |
| **Question** | **Date** | **Date** |
| 1. Do you have flu-like symptoms: fever > 38°C, cough, sore throat or difficulty breathing? | **□** Yes **□** No | **□** Yes  **□** No |
| Have you or any member of their household tested positive for COVID-19? When was the diagnosis made and when did the patient experience their most recent symptoms, if any? | **□** Yes  **□** No | **□** Yes  **□** No |
| 1. Have you experienced any flu-like symptoms (see question 1) in the past fourteen (14) days? | **□** Yes  **□** No | **□** Yes  **□** No |
| 1. Have you been in contact with someone outside your household who has tested positive for COVID-19 or had flu-like symptoms? | **□** Yes  **□** No | **□** Yes  **□** No |
| 1. Have you been in contact with somebody with flu-like symptoms who has also received a negative or inconclusive COVID-19 test? | **□** Yes  **□** No | **□** Yes  **□** No |
| 1. Did you travel to areas marked by transmission of COVID-19? | **□** Yes  **□** No | **□** Yes  **□** No |
| 1. Have you worked in or attended a health care facility where COVID-19 patients were being treated? | **□** Yes  **□** No | **□** Yes  **□** No |
| 1. Have you been recently admitted with severe pneumonia? | **□** Yes  **□** No | **□** Yes  **□** No |
| 1. Are you over the age of 60 years? | **□** Yes  **□** No | **□** Yes  **□** No |
| 1. Other symptoms: chills, loss of taste, loss of smell, muscle pain, headache. | **□** Yes  **□** No | **□** Yes  **□** No |

Dr \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

COVID-19 Daily Screening Log

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| DATE | NAME | TEMPER-ATURE  <38° C | COUGH | NEW SHORTNESS OF BREATH | ASKED TO GO HOME  (Note time of dismissal) |
|  |  |  | **□** Yes  **□** No | **□** Yes  **□** No | **□** Yes  **□** No |
|  |  |  | **□** Yes  **□** No | **□** Yes  **□** No | **□** Yes  **□** No |
|  |  |  | **□** Yes  **□** No | **□** Yes  **□** No | **□** Yes  **□** No |
|  |  |  | **□** Yes  **□** No | **□** Yes  **□** No | **□** Yes  **□** No |
|  |  |  | **□** Yes  **□** No | **□** Yes  **□** No | **□** Yes  **□** No |
|  |  |  | **□** Yes  **□** No | **□** Yes  **□** No | **□** Yes  **□** No |
|  |  |  | **□** Yes  **□** No | **□** Yes  **□** No | **□** Yes  **□** No |
|  |  |  | **□** Yes  **□** No | **□** Yes  **□** No | **□** Yes  **□** No |
|  |  |  | **□** Yes  **□** No | **□** Yes  **□** No | **□** Yes  **□** No |
|  |  |  | **□** Yes  **□** No | **□** Yes  **□** No | **□** Yes  **□** No |