Name: _____

Date: _____

Time: _____

Purpose of Visit: _____

Visitor Screening Questionnaire

1. Do you have any of the following **new or worsening** symptoms or signs?

New or worsening cough	Yes ____	No _____
Shortness of breath	Yes ____	No _____
Sore throat	Yes ____	No _____
Runny nose, sneezing or nasal congestion (not allergies)	Yes ____	No _____
Hoarse voice	Yes ____	No _____
Difficulty swallowing	Yes ____	No _____
New smell or taste disorder(s)	Yes ____	No _____
Nausea/vomiting, diarrhea, abdominal pain	Yes ____	No _____
Unexplained fatigue/malaise	Yes ____	No _____
Chills	Yes ____	No _____
Headache	Yes ____	No _____

- **Have you travelled outside of Canada or had close contact with anyone that has travelled outside of Canada in the past 14 days?** ☐ **Yes** ☐ **No**
- **Do you have a fever?** ☐ **Yes** ☐ **No**
- **Have you had close contact with anyone with respiratory illness or a confirmed or probable case of COVID-19?** ☐ **Yes** ☐ **No**