Visitor Screening Questionnaire

Family Last Name: ______________________________

Date: ______________________________

Time: ______________________________

Purpose of Visit: ______________________________

Phone Number: ______________________________
First Time Visitors

Family members attending today;

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________

Does ***anyone in your family*** have any of the following **new or worsening** symptoms or signs?

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

- **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**