



Patient Name: _____ Date: _____

Please select all that apply to you

Have you tested positive for COVID-19 or are you awaiting results for a COVID-19 test?

Do you have any of the following cold or flu-like symptoms (even mild ones):

- Cough
- Shortness of breath
- Sore throat and painful swallowing
- Stuffy or runny nose
- Loss of sense of smell
- Headache
- Muscle aches
- Fatigue
- Loss of appetite
- Fever
- Gastrointestinal issues

Are you experiencing any of the following symptoms:

- Mild to moderate shortness of breath
- Inability to lie down because of difficulty breathing
- Chronic health conditions that you are having difficulty managing because of difficulty breathing

Are you experiencing any of the following symptoms:

- Severe difficulty breathing (e.g. struggling to breathe or speaking in single words)
- Severe chest pain
- Having a very hard time waking up
- Feel confused
- Losing consciousness

Have you traveled to any countries outside Canada (including the United States) within the last 14 days?

No to All **Patient Signature:** _____