OWEN SOUND
DENTAL CLINIC

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Screen Questions for COVID-19
Patients and Visitors

Name: _____ Temperature: _____

Please circle **YES** or **NO**.

1. Have you had close contact with anyone with acute respiratory illness or traveled outside of Ontario in the past 14 days? **YES NO**
2. Have you been in close contact with a confirmed case of COVID-19? **YES NO**
3. Have you been confirmed to have COVID-19? **YES NO**
4. Do you have any of the following symptoms:

Fever	**YES**	**NO**
New onset of cough	**YES**	**NO**
Worsening chronic cough	**YES**	**NO**
Shortness of breath	**YES**	**NO**
Difficulty breathing	**YES**	**NO**
Sore throat	**YES**	**NO**
Decrease or loss of sense of taste or smell	**YES**	**NO**
Chills	**YES**	**NO**
Headaches	**YES**	**NO**
Unexplained fatique/malaise/muscle aches	**YES**	**NO**
Nausea/vomiting, diarrhea, abdominal pain	**YES**	**NO**
Pink eye	**YES**	**NO**
Runny nose/nasal congestion without known cause	**YES**	**NO**

5. If you are over the age of 70 circle if you are experiencing any of these symptoms: delirium, unexplained or increased number of falls, acute functional decline, or worsening of chronic conditions? **YES NO**

_____ _____
Signature Date

Name of Screener: _____