



COVID-19 SCREENING QUESTIONS

We require you to fill out this Alberta Health Services questionnaire to assist in determining your fitness to attend the clinic during the COVID-19 pandemic to provide a safe environment for staff, patients and families.

The information in this questionnaire is collected under the authority of FOIP section 33 (c) and will be used and disclosed solely for the above purposes.

The questionnaire intends to identify **NEW symptoms or WORSENING of symptoms** that are related to allergies, chronic or pre-existing conditions.

Date: _____

Name: _____ Signature: _____

1.	Do you have any of the following symptoms which are new or worsened if associated with allergies, chronic or pre-existing conditions: fever, cough, shortness of breath, difficulty breathing, sore throat, and/or runny nose?	Yes	No
2.	Have you returned to Canada from outside the country (including USA) in the past 14 days?	Yes	No
In the past 14 days, at work or elsewhere, while not wearing appropriate personal protective equipment:			
3.	Did you have close contact with someone who has a probable or confirmed case of COVID19?	Yes	No
4.	Did you have close contact with a person who had acute respiratory illness that started within 14 days of their close contact to someone with a probable or confirmed case of COVID-19?	Yes	No
5.	Did you have close contact with a person who had acute respiratory illness who returned from travel outside of Canada in the 14 days before they became sick?	Yes	No

If you circled "YES" to any of the above, please refrain from coming to the clinic until self-isolation is complete

(For OFFICE USE ONLY):

Date:						
Patient Initial:						