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total rehab
orthopedic & athletic medicine

Please complete this questionnaire. This form will be kept in your file.

1. **Have you had close contact with anyone with acute respiratory Illness or travelled outside of Ontario in the past 14 days?**

   ☐Yes ☐ No

2. **Have you had a confirmed case of COVID-19 or had close contact with a confirmed case of COVID-19?**

   ☐Yes ☐No

Does the person 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**
• Difficulty swallowing	☐ **Yes**	☐**No**
• Decrease or loss of sense of taste or smell	☐ **Yes**	☐**No**
• Chills	☐ **Yes**	☐**No**
• Headaches	☐ **Yes**	☐**No**
• Unexplained fatigue/malaise/muscle aches (myalgias)	☐ **Yes**	☐**No**
• Nausea/vomiting, diarrhea, abdominal pain	☐ **Yes**	☐**No**
• Pink eye (conjunctivitis)	☐ **Yes**	☐**No**
• Runny nose/nasal congestion without other known cause	☐ **Yes**	☐**No**

If you are 70 years of age or older, are you experiencing any of the following symptoms: delirium, unexplained or increased number of falls, acute functional decline, or worsening of chronic conditions?

☐ Yes ☐No

If you answer yes to any questions please call the clinic first before your appointment

I certify that I have answered the questions truthfully

Name: ____

Signed: ____

Date: ____