Cambridge Medical Centre
COVID-19 Screening Questionnaire #1

Date _____

Name _____

Date of birth _____ NHI Number _____

Address _____

Email _____

Phone _____

Have you had contact with someone who has **tested positive** for Coronavirus? ☐ Yes ☐ No

Dates of contact _____

Nature of contact ☐ Shared home ☐ Workplace ☐ Other _____

Have you had contact with someone **suspected** of Coronavirus? ☐ Yes ☐ No

Dates of contact _____

Nature of contact ☐ Shared home ☐ Workplace ☐ Other _____

Isolation of persons who have had close contact is recommended.

Have you had contact with someone **recommended for isolation**? ☐ Yes ☐ No

If you responded "yes" how was that person suspected of exposure exposed to the virus?

_____

Have you traveled recently? ☐ Yes ☐ No

Dates of travel _____

Which countries did you traveled to, including stopovers?

1 _____ 3 _____

2 _____ 4 _____

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Are you having symptoms? ☐ Yes ☐ No

When did your symptoms start? _____

What symptoms are you experiencing?

- ☐ Temperature 38C or higher
- ☐ Chills
- ☐ Cough
- ☐ Difficulty breathing
- ☐ Diarrhoea
- ☐ Headache
- ☐ Muscle aches
- ☐ Nausea
- ☐ Sneezing
- ☐ Sore throat
- ☐ Vomiting
- ☐ Other _____

Do you have any chronic medical conditions?

- ☐ Cancer
  Currently on chemotherapy? ☐ Yes ☐ No
  Doctor in charge of cancer care _____
- ☐ Chronic lung disease (COPD, asthma)
- ☐ Diabetes
- ☐ Heart disease
- ☐ Impaired immune system
- ☐ Other (specify) _____
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Neurologic disease

Nursing Notes _____

☐ Over 70 ☐ Chronic conditions ☐ Discharged home ☐ Referred for Step 2

Nurse signature _____ Date _____

Medical officer review _____ Date _____