COVID-19 Screening Questionnaire

Dr. Sheila Bowling – Village Medical Clinic
Unit 1 - 9089 Glover Road
Fort Langley, BC
V1M 2S4
604-888-8300

Please print and complete this COVID-19 Screening Questionnaire prior to an in-office appointment and bring with you to your appointment.

Patient First Name: ___________________________Patient Last Name: _________________________

Phone Number: _____________________________ Email Address: _____________________________

Are you experiencing any of the following COVID-19-like symptoms:
(It is very important that you are truthful in your self-assessment so that we may provide appropriate care.)

CHECK ALL THAT APPLY

☐ Fever
☐ Cough
☐ Shortness of breath
☐ Headache
☐ Chills
☐Shore throat or painful swallowing
☐ Loss of sense of smell
☐ Loss of sense of taste
☐ Loss of appetite
☐ Runny nose
☐ Muscle aches
☐ Fatigue
☐ Nausea and/or vomiting
☐ Diarrhea
☐ I have none of these symptoms

In the last 14 days have you returned from travel outside of Canada?

☐ Yes ☐ No

In the last 14 days have you been in close contact with anyone diagnosed with laboratory-confirmed COVID-19?

☐ Yes ☐ No

In the last 14 days have you lived or worked in a setting that is part of a COVID-19 outbreak?

☐ Yes ☐ No

In the last 14 days have you been advised to self-isolate or quarantine at home by public health?

☐ Yes ☐ No

In the past 28 days have you had a positive COVID-19 test?

☐ Yes ☐ No

If yes, what was the date you were tested? ____

☐ **If the answer to all the above questions is no, please check this box to confirm**

If you have answered yes to any of the questions, please call us and DO NOT come to the office in person without speaking to the office staff.