DR. JUDY STURM & ASSOCIATES

Just a little obsessed with your smile

PATIENT NAME: **TEAM SCREENER:**

TEMP:

Pulse: **Date:**		
	Pre-Screen	**In-Office**
Have you had close contact with anyone with acute respiratory illness or travelled outside of Ontario in the past 14 days?	**YES NO**	**YES NO**
Do you have a CONFIRMED case of COVID-19 or had close contact with a confirmed case of COVID-19?	**YES NO**	**YES NO**
Do you have any of the following symptons: A - Fever B - Worsening chronic cough C - Shortness of breath D - New onset of cough E - Sore throat F - Difficulty breathing G - Decrease or loss of sense of taste or smell H - Chills I - Headaches J - Unexplained fatigue / malaise / muscle aches (myalagias) K- Nausea / Pink Eye (conjunctivitis)/ Vomiting Diarrhea / Abdominal Pain	**YES NO**	**YES NO**
Are you 70 years of age or older, experiencing any of the following: A - Delirium, Worsening of chronic conditions, Unexplained or increased number of falls or acute functional decline	**YES NO**	**YES NO**