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COVID -19 Medical History Form

Covid-19 symptoms are similar to other respiratory illnesses, including the flu and the common cold.

Please **circle** any of the following symptoms that pertain to you:

Fever, Chills, Cough, Shortness of breath, Sore throat, Painful swallowing, Runny nose, Nasal congestion, Loss of sense of smell, Headache, Muscle aches, Fatigue, Loss of appetite.

Have you travelled to any countries outside Canada (including the United States) within the last 14 days?

Yes/No

Have you been in contact with anyone who has confirmed Covid-19 or has been exposed to Covid-19 within the last 14 days?

Yes/No

Patient Name_____

Name of person who completed this form _____

Signature of person who completed this form _____

Date signed: _____