Cabin Country Realty Ltd.

Ontario

Required Screening Questions

For individuals who are 18 years of age and older.

1. Do you have any of the following new or worsening symptoms or signs? Symptoms should not be chronic or related to other known causes or conditions.

Choose any/all that are new, worsening, and not related to other known causes or medical conditions.

Fever and/or chills Temperature of 37.8 degrees Celsius/100 degrees Fahrenheit or higher	☐ Yes	☐ No
Cough or barking cough (croup) Continuous, more than usual, making a whistling noise when breathing, not related to other known causes or conditions (for example, asthma, post-infectious reactive airways, COPD)	☐ Yes	☐ No
Shortness of breath Out of breath, unable to breathe deeply, not related to other known causes or conditions (for example, asthma)	☐ Yes	☐ No
Decrease or loss of smell or taste Not related to other known causes or conditions (for example, allergies, neurological disorders)	☐ Yes	☐ No
Sore throat Not related to other known causes or conditions (for example, seasonal allergies, acid reflux)	☐ Yes	☐ No
Difficulty swallowing Painful swallowing, not related to other known causes or conditions	☐ Yes	☐ No

Pink eye Conjunctivitis, not related to other known causes or conditions (for example, reoccurring styes)	☐ Yes	☐ No
Runny or stuffy/congested nose Not related to other known causes or conditions (for example, seasonal allergies, being outside in cold weather)	☐ Yes	☐ No
Headache that's unusual or long lasting Not related to other known causes or conditions (for example, tension-type headaches, chronic migraines)	☐ Yes	☐ No
Digestive issues like nausea/vomiting, diarrhea, stomach pain Not related to other known causes or conditions (for example, irritable bowel syndrome, menstrual cramps)	☐ Yes	☐ No
Muscle aches that are unusual or long lasting Not related to other known causes or conditions (for example, a sudden injury, fibromyalgia)	☐ Yes	☐ No
Extreme tiredness that is unusual Fatigue, lack of energy, not related to other known causes or conditions (for example, depression, insomnia, thyroid dysfunction)	☐ Yes	☐ No
Falling down often For older people	☐ Yes	☐ No

Name: _____ Date: _____

Signature: _____