Please fill out the following Covid-19 questionnaire **honestly** to ensure the safety of everyone within this place of business.

1. Do you have any of the following symptoms: severe difficulty breathing (e.g., struggling for each breath, speaking in single words), chest pain, confusion, extreme drowsiness or loss of consciousness?

YES/NO

2. Do you have shortness of breath at rest or difficulty breathing when lying down?

YES/NO

3. Do you have a new onset or worsening of any of the following symptoms?

- fever / chills
- cough
- sore throat / hoarse voice
- shortness of breath
- loss of taste or smell
- vomiting or diarrhea for more than 24 hours

YES/NO

4. Do you have a new onset of 2 or more of any of the following symptoms?

- runny nose
- muscle aches
- fatigue
- conjunctivitis (pink eye)
- headache
- skin rash of unknown cause
- nausea or loss of appetite
- if the patient is an infant, poor feeding

YES/NO

5. Have you been in close contact in the last 14 days with someone that is confirmed to have COVID-19?

YES/NO

6. Have you travelled outside of Manitoba in the last 14 days?

YES/NO

Patient Signture: _____

Date: _____