hyperbaricmontreal.com

LES COURS
HYPERBARIC CENTRE

CORONAVIRUS COVID 19 QUESTIONNAIRE

Family name

First name

Date

1) Have you had any of the following symptoms in the last 14 days?

Yes	No	
☐	☐	Fever, Chills or history of fever
☐	☐	Nasal Congestion
☐	☐	Cough
☐	☐	Sore Throat
☐	☐	New onset of headache
☐	☐	Acute loss of smell
☐	☐	Shortness of breath/respiratory difficulties
☐	☐	Loss of appetite

2) Have you been in contact with a Covid 19 case in the last 14 days? Yes ☐ No ☐

3) Have you been in contact with someone with respiratory tract infection in the last 14 days (such as a cold, pneumonia, etc) ? Yes ☐ No ☐

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