ADVANCE ENDOSCOPY
& SPECIALIST CENTER
advanceendoscopy.com

COVID-19 ASSESSMENT FORM

Assessment Date : _____

Patient Information :

Name : _____

DOB (YYYY/MM/DD) _____

HC # _____

Gender : M / F _____

Address : _____

Phone # : _____

Recent Travel History (within 1 month):

Travel To : _____

Date of Travel : _____ (YYYY/MM/DD)

Date of Return: _____ (YYYY/MM/DD)

Exposure History

	Y	N
Exposure to Confirmed COVID-19 case	☐	☐

Details : _____

Patient's Name : _____

Patient's Signature and date _____

Please indicate if you are having any of the following symptomas:

	Y	N
Chills / Fever (Temp. 37.8 C or greater)	☐	☐
New or worsening Cough/ Nasal Congestion	☐	☐
Sore Throat	☐	☐
Fatigue	☐	☐
Chest Tightness/Pressure	☐	☐
Shortness of Breath (Dyspnea)	☐	☐
Runny Nose / Nasal congestion	☐	☐
Headache	☐	☐
Nausea/Vomiting / Abdominal pain	☐	☐
Diarrhea /Cramps	☐	☐
Sudden Loss of Smell/Taste Taste disorder	☐	☐
Difficulty swallowing	☐	☐

Atypical Symptoms: Please circle

Malaise/myalgias - Acute functional decline

Delirium (acutely altered mental status and inattention) - Croup

Unexplained or increased number of falls - Conjunctivitis

Exacerbation of chronic conditions

Other : _____

2227 South Millway, Suite 303 Mississauga, ON, L5L 3R6
Tel:905.569.7007 Fax: 905.569.7056
Email: advanceendoscopy@gmail.com

688 Coxwell Avenue, Suite 206, Toronto, ON, M4C 3B7
Tel:416.463.7007 Fax: 416.463.7008
Email: advendo.toronto@gmail.com

222 King Street East, Suite 3100, Bowmanville, ON, L1C 1P6
Tel:905.419.7007 Fax: 905.419.7008
Email: advendo.bowmanville@gmail.com