

COVID Self-Assessment (Ontario version)

Are you currently experiencing any of these symptoms?

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

The symptoms listed here are the most commonly associated with COVID-19.

Anyone who is sick or has any symptoms of illness, including those not listed below, should stay home and seek assessment from their health care provider if needed.

Fever and/or chills

Temperature of 37.8 degrees Celsius/100 degrees Fahrenheit or higher

Cough or barking cough (croup)

Continuous, more than usual, making a whistling noise when breathing (not related to asthma, post-infectious reactive airways, COPD, or other known causes or conditions you already have)

Shortness of breath

Out of breath, unable to breathe deeply (not related to asthma or other known causes or conditions you already have)

Decrease or loss of taste or smell

Not related to seasonal allergies, neurological disorders, or other known causes or conditions you already have

Muscle aches/joint pain

Unusual, long-lasting (not related to getting a COVID-19 vaccine and/or flu shot in the last 48 hours, a sudden injury, fibromyalgia, or other known causes or conditions you already have)

Extreme tiredness

Unusual, fatigue, lack of energy (not related to getting a COVID-19 vaccine and/or flu shot in the last 48 hours, depression, insomnia, thyroid dysfunction, or other known causes or conditions you already have)

Sore throat

Painful or difficulty swallowing (not related to post-nasal drip, acid reflux, or other known causes or conditions you already have)

Runny or stuffy/congested nose

(Not related to seasonal allergies, being outside in cold weather, or other known causes or conditions you already have)

Headache

New, unusual, long-lasting (not related to getting a COVID-19 vaccine and/or flu shot in the last 48 hours, tension-type headaches, chronic migraines, or other known causes or conditions you already have)

Nausea, vomiting and/or diarrhea

(Not related to irritable bowel syndrome, anxiety, menstrual cramps, medication side effects, or other known causes or conditions you already have)

None of the above

In the last 10 days, has someone you live with:

- been sick with symptoms associated with COVID-19?

and/or

- tested positive for COVID-19 (on a rapid antigen test or PCR test)?

No

Yes

In the last 10 days, have you tested positive on a rapid antigen test or home-based self-testing kit?

No

Yes

In the last 10 days, have you received a COVID Alert exposure notification on your cell phone?

No

Yes

In the last 10 days, have you been identified as a “close contact” of someone who currently has COVID-19 (confirmed by a PCR or rapid antigen test)?

If public health has advised you that you do not need to self-isolate, select “No.”

No

Yes

In the last 14 days, have you travelled outside of Canada?

If exempt from federal quarantine requirements as directed by the border agent at your point of entry (for example, you have two or more doses of a COVID-19 vaccine and have met the specific conditions, or an essential worker who crosses the Canada-US border regularly for work), select “No.”

No

Yes