Patient Screening Form

PATIENT NAME:
DATE:

QUESTIONNAIRE	PRE-APPOINTMENT	IN-OFFICE
Do you have a fever or have you/they felt hot or feverish recently (14-21 days)?	□ Yes □ No	□ Yes □ No
Have you have had any flu-like symptoms recently (14-21 days)? ● Cough ● Shortness of breath ● Fever ● Chills ● Repeated shaking ● Diarrhea ● Vomiting ● Muscle ache ● Headache ● Sore throat ● Loss of taste/smell ● Malaise ● Nausea ● Fatigue	□ Yes □ No	□ Yes □ No
Are you having shortness of breath or other difficulties breathing?	□ Yes □ No	□ Yes □ No
Any other flu-like symptoms such as gastrointestinal upset, headache, or fatigue?	□ Yes □ No	□ Yes □ No
Are you experienced recent loss of taste or smell?	□ Yes □ No	□ Yes □ No
Do you have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	□ Yes □ No	□ Yes □ No
Have you traveled in the past 14 days to any regions affected by COVID-19? (as relevant to your location)	□ Yes □ No	□ Yes □ No
Are you awaiting results of a lab test for COVID-19?	□ Yes □ No	□ Yes □ No
Have you tested positive for COVID-19? If so, when?	□ Yes □ No	□ Yes □ No
Have you or a family member previously been asked to self-isolate/self-quarantine recently (14-21 days)?	□ Yes □ No	□ Yes □ No
Have you had close contact with an individual diagnosed with COVID-19 infection recently (14-21 days)?	□ Yes □ No	□ Yes □ No

Yes responses to any of these would likely indicate a deeper discussion with the dentist before proceeding with elective dental treatment. Please call to inform us at (714) 827-0206.