



CORONAVIRUS SCREENING QUESTIONNAIRE

Date: _____ Temperature: _____

Name: _____

First

Last

Date of Birth: / / (MM/DD/YYYY)

Please circle Yes or No for the following questions:

- | | | | |
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| 1. | Do you/they have fever or have you/they felt hot or feverish recently (14-21 days)? | YES | NO |
| 2. | Are you/they having shortness of breath or other difficulties breathing? | YES | NO |
| 3. | Do you/they have a cough? | YES | NO |
| 4. | Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue? | YES | NO |
| 5. | Have you/they experienced recent loss of taste or smell? | YES | NO |
| 6. | Are you/they in contact with any confirmed COVID-19 positive patients? | YES | NO |
| 7. | Is your/their age over 60? | YES | NO |
| 8. | Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders? | YES | NO |
| 9. | Have you/they been tested positive for COVID-19? | YES | NO |
| 10. | Have you/they traveled in the past 14 days outside your/their state of residence? | YES | NO |

Patients who are well but have a sick family member at home with COVID-19 should consider postponing/rescheduling elective treatment. Positive responses to any of these would likely indicate a deeper discussion with the dentist before proceeding with dental treatment.

Patient or Legal Guardian Signature