CORONA VIRUS SCREENING QUESTIONNAIRE

- Name

- Date of Birth

(MM/DD/YYYY)

- Do you/they have fever, or have you/they felt hot or feverish recently (14-21 days)?
  - YES
  - NO

- Are you/they having shortness of breath or other difficulties breathing?
  - YES
  - NO

- Do you/they have a cough?
  - YES
  - NO

- Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?
  - YES
  - NO

- Have you/they experienced recent loss of taste or smell?
  - YES
  - NO

•Are you/they in contact with any confirmed COVID-19 positive patients?

◦YES

◦NO

•Is your/their age over 60? *

◦YES

◦NO

•Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?

◦YES

◦NO

•Have you/they traveled in the past 14 days to any regions affected by COVID-19? (as relevant to your location)

◦YES

◦NO

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

•Signature of Patient or Legal Guardian*