Patient Screening Form

Patient Name: _____

	Pre – Appointment	In – Office
	Date:	Date:
Do you have fever or have you felt hot and/or feverish recently? (14-21 days)	YES: NO:	YES: NO:
Have you taken meds to reduce a fever in the last 14 days?	YES: NO:	YES: NO:
Are you have shortness of breath or other difficulties breathing?	YES: NO:	YES: NO:
Do you have a cough?	YES: NO:	YES: NO:
Any other flu-like symptoms, such as gastrointestinal upset, headache, or fatigue?	YES: NO:	YES: NO:
Have 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/areas affected by COVID-19?	YES: NO:	YES: NO:
Have you ever tested positive for COVID-19?	YES: NO:	YES: NO:
Are you in contact with any confirmed COVID-19 positive patients? Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.	YES: NO:	YES: NO: