Patient Screening Form

Patient Name:_____ Date:_____

Do you/they have a 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? *Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.*	☐ Yes ☐ No
Are you/they over the age of 60?	☐ Yes * ☐ No
Do you/they have heart disease, lung disease, kidney disease, diabetes, or any auto-immune disorders?	☐ Yes * ☐ No
In the last 14 days have you/they been in an area where COVID-19 is widespread?	☐ Yes ☐ No

** Individuals that answer "yes" to these questions fall in to categories that have been identified by the CDC as people that might have a higher risk of developing a severe illness from COVID-19. If you wish to postpone your appointment because of this, we completely respect your decision. Please contact the office to reschedule.*