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PATIENT SCREENING FORM

Patient Name:

	PRE-APPOINTMENT	IN-OFFICE
	Date:	Date:
Do you/they have fever or have you/they felt hot or feverish recently (14-21 days)?	❑ Yes ❑ No	❑ Yes ❑ No
Are you/they having shortness of breath or other difficulties breathing?	❑ Yes ❑ No	❑ Yes ❑ No
Do you/they 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/they experienced recent loss of taste or smell?	❑ Yes ❑ No	❑ Yes ❑ No
Are you/they in contact with any 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
Is your/their age over 60?	❑ Yes ❑ No	❑ Yes ❑ No
Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	❑ Yes ❑ No	❑ 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	❑ Yes ❑ No