COVID-19 Patient Screening Form

Patient Name:_____ Age_____

Body Temperature today:	Date:
Do you/they have fever or have you/they felt hot or feverish recently (14-21 days)?	Yes No
Are you having shortness of breath or other difficulties breathing?	Yes No
Do you have a cough?	Yes No
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	Yes No
Have you experienced recent loss of taste or smell?	Yes No
Have you traveled in the past 14 days?	Yes No
Do you have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	Yes No
Are you in contact with any confirmed COVID-19 positive Patients? *If yes, patient must postpone elective treatment*	Yes No
Have you been tested for COVID-19 or had an antibody test?	Yes No

Positive responses to any of these would likely indicate a deeper discussion with the dentist before proceeding with elective dental treatment.

· For testing, see the list of State and Territorial Health Department Websites for your specific area's information.