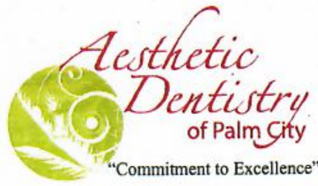

COVID-19 Patient Screening Form

Patient Name____

	Pre-Appointment		In -Office	
PATIENT TEMPERATURE:	Date:		Date:	
Do you have a fever or have you felt hot or feverish recently? (14-21 days)	Yes	No	Yes	No
Are you having 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
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 postpone elective treatment.	Yes	No	Yes	No
Have you traveled in the past 14 days to any regions affected by COVID-19?	Yes	No	Yes	No

Patient Signature____

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