Patient Screening Form

Patient Name: Cell Phone:

	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 chills, chills with shaking 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 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
Have you/they developed a rash anywhere on their body or discoloration of toes?	☐ 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
Is your/their age over 60?	☐ Yes ☐ No	☐ Yes ☐ No
Have you/they attended any large group functions in the past 14 days?	☐ Yes ☐ No	☐ Yes ☐ No

I ACKNOWLEDGE THAT MY ANSWERS ARE TRUE AND ACCURATE AND I AGREE TO NOTIFY THE OFFICE SHOULD I DEVELOP SYMTOMS OR TEST POSTIVIVE FOR COVID-19 IN THE NEXT 2 DAYS.

Patient Signature:_____ **Date:**_____