COVID-19 SCREEENING FORM

PATIENT NAME		PRE-APPOINTMENT	IN-OFFICE	
		CIRCLE	CIRCLE	
	Do you/they have or have you/they felt hot or feverish recently (14-21 days)?	YES OR NO	YES OR NO	
	Are you/they having shortness of breath or other difficulties breathing?	YES OR NO	YES OR NO	
	Do you/they have a cough?	YES OR NO	YES OR NO	
	Any other flu-like symptoms, such as gastrointestinal upset, headache or fagtigue?	YES OR NO	YES OR NO	
	Have you/they experienced recent loss of taste or smell?	YES OR NO	YES OR 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 consider postponing elective treatment.	YES OR NO	YES OR NO	
	Is your/their age over 60?	YES ON NO	YES OR NO	
	Do you/they have heart disease, lung disease, kidney disease, diabietes or any auto-immune disorders?	YES OR NO	YES OR NO	
	Have you/they traveled in the past 14 days to any regions affected by COVID-19? (OUTSIDE KENTUCKY OR THE USA)	YES OR NO	YES OR NO	
	POSITIVE RESPONSES TO ANY OF THESE QUESTIONS WOULD LIKELY INDICATE A DEEPER DISCUSSION WITH THE DENTIST BEFORE PROCEEDING WITH ELECTIVE TREATMENT			
	Temperature result			
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Patient signature		Date		
Doctor/hygiene signature		Date		