ADA COVID PATIENT SCREENING FORM

Have you had COVID-19? * Yes No

Date?

Do you/they have fever or have you/they felt hot or feverish recently (14-21 days)? * Yes No

Are you/they experiencing new shortness of breath or difficulties breathing? * Yes No

Do you/they have a new cough? Yes No

Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue? * Yes No

Have you/they experienced recent loss of taste or smell? * 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

Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders? * Yes No

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

(Signature) *

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