Patient Screening Form

Patient Name: _____ Temp: _____

	Pre-Appointment Date:		**In Office** 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 or fatigue?	Yes	No	Yes	No
Have you/they experienced recent loss of taste/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
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