COVID-19 Patient Screening Form

Patient Name____

1) Has the patient returned from travel to a non-U.S. country in the previous 14 days?
   ☐ Yes ☐ No

   If yes, please name the country/countries visited

   ____

2) Is the patient currently experiencing any of the following flu-like symptoms:
   ☐ Yes ☐ No

   If yes, which:

   _______ Fever
   _______ Chills
   _______ Muscle aches
   _______ Runny nose
   _______ Abdominal pain and/or diarrhea
   _______ Loss of sense of taste or smell
   _______ Sore Throat
   _______ Shortness of breath
   _______ Nausea/Vomiting
   _______ Headache
   _______ Cough

3) Have you been in close contact with someone who has been ill with cough and/or fever within the past 14 days? ☐ Yes ☐ No

4) Do you have any of the following COVID-19 health risk factors:

   _______ Over 65
   _______ Lung condition
   _______ Immune compromised (HIV, cancer, other)
   _______ Heart condition
   _______ High Blood Pressure
   _______ Diabetes
   _______ Pregnant

5) Current patient temperature ____

I have interviewed the patient and confirm that they are approved to receive dental treatment.

Employee Signature____

Employee Name ____

Date____