Covid-19 Patient Screening Form

Patient Name _____

Date _____ Temperature _____

Have you had a fever or above normal temperature in the last 14 days?	YES	NO
Are you experiencing shortness of breath or having trouble breathing?	YES	NO
Do you have a dry cough?	YES	NO
Do you have a runny nose?	YES	NO
Have you recently lost or had a reduction in your sense of smell or taste?	YES	NO
Do you have a sore throat?	YES	NO
Are you experiencing chills or repeated shaking with chills?	YES	NO
Do you have unexplained muscle pain?	YES	NO
Do you have a headache?	YES	NO
Even if you don't currently have any of the above symptoms, have you experienced any of these symptoms in the last 14 days?	YES	NO
Have you been in contact with someone who has tested positive for COVID-19 in the last 14 days?	YES	NO
Have you been tested for COVID-19 in the last 14 days?	YES	NO
Have you traveled outside of NY State in the past 14 days? If so where?_____	YES	NO

I agree to notify the dental practice if within 2 days I become ill with COVID-19 symptoms or test positive for COVID-19. I understand the dental practice has a legal and ethical obligation to inform me if a staff person I had contact with tested positive for COVID-19 within 2 days.

SIGNATURE _____