COVID-19 PATIENT SCREENING QUESTIONS

PATIENT NAME: _____ **DOB:** _____

PHONE NUMBER: _____ **AGE:** _____

QUESTIONS:	PRE-SCREEN DATE:_____		ARRIVAL DATE:_____	
1. Are you fully vaccinated or have fully recovered from a documented COVID-19 infection in the past 90 days?	☐ YES	☐ NO	☐ YES	☐ NO
2. Have you experienced any of the following symptoms in the past 48 hours: • fever/chills (T>100.0° F) • cough • shortnes of breath or difficulty breathing • fatigue • muscle or body aches • headache • new loss of taste/smell • sore throat • congestion/runny nose • nausea, vomiting • diarrhea	☐ YES	☐ NO	☐ YES	☐ NO
3. Do you live with or care for someone who has COVID-19?	☐ YES	☐ NO	☐ YES	☐ NO
4. Are you isolating or quarantining because you tested positive for COVID-19 or are concerned you may be sick?	☐ YES	☐ NO	☐ YES	☐ NO
5. Have you been in close contact with anyone in the past 14 days who may have a COVID-19 infection?	☐ YES	☐ NO	☐ YES	☐ NO
6. Have you traveled outside of your county in the past 10 days? If yes, where?_____	☐ YES	☐ NO	☐ YES	☐ NO
7. Do you have heart, kidney, or lung disease?	☐ YES	☐ NO	☐ YES	☐ NO
8. Do you have any other condition that might increase your risk of infection such as cancer or diabetes?	☐ YES	☐ NO	☐ YES	☐ NO

This serves as a basic template. Additional questions regarding health issues may be added based on the professional opinion of the dentist.

Any positive responses need to be reviewed by the dentist. If the patient has a temperature, the advice to follow-up with their personal healthcare provider may be the most common response, but temperature alone could be an indication of a dental issue that should be further evaluated.

Reference: https://www.cdc.gov/screening/paper-version.pdf

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