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PATIENT SCREENING QUESTIONNAIRE
COVID-19

Patient name:_____ Last Name_____

-Have you been tested for Covid-19 and if yes then when and what were the results?	Yes____ No____
-Do you have fever of have you felt hot or feverish recently (14-21 days)?	Yes____ No____
-Are you having shortness of breath or other difficulties breathing?	Yes____ No____
-Do you have a cough?	Yes____ No____
-Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	Yes____ No____
-Are you experienced recent loss of taste or smell?	Yes____ No____
-Are you in contact with any confirmed Covid-19 positive patients?	Yes____ No____
-Have you traveled in the past 14 days to any region affected by COVID-19? (as relevant to your location)	Yes____ No____

Positive responses to any of these would likely indicated a deeper discussion with Dr. Watkins before proceeding with elective dental treatment.

Response Date:_____