Covid-19 Screen

Patient Name: **Date:**

	IN-OFFICE	
Do you/they have fever or have you/they felt hot or feverish recently (14-21 days)?	**Yes**	**No**
Are you/they having shortness of breath or other difficulties breathing?	**Yes**	**No**
Do you/they have a cough?	**Yes**	**No**
Any other flu-like symptoms such as gastrointestinal upset, headache or fatigue?	**Yes**	**No**
Have you/they experienced recent loss of taste or smell?	**Yes**	**No**
Have you/they been in contact with any confirmed COVID-19 positive patients? ***Patients who are well but have a sick family member at home with COVID-19 should consider postponing elective treatment***	**Yes**	**No**
Are you/they over the age of 60?	**Yes**	**No**
Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune diseases?	**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**

Positive responses to any of these would likely indicate a deeper discussion with the dentist before proceeding with elective dental treatment

- **For testing, see the list of State and Territorial Health Department Websites for your specific area's information**