COVID- 19 PATIENT SCREENING FORM

		Please check Yes or No	
1	Do you have a fever or have you felt hot or feverish recently (14-21 days)?	☐	☐
2	Do you have a dry cough?	☐	☐
3	Have you experienced shortness of breath or other difficulties breathing?	☐	☐
4	Do you have a runny nose?	☐	☐
5	Do you have any recent onset of headache or sore throat?	☐	☐
6	Do you have muscle pain?	☐	☐
7	Do you have flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	☐	☐
8	Have you recently lost or had a reduction in your sense of taste or smell?	☐	☐
9	Have you been in contact with someone who has tested positive for COVID-19?	☐	☐
10	Have you tested positive for COVID-19?	☐	☐
11	Are you over the age of 65?	☐	☐
12	Do you have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	☐	☐

Patient Name:_____

This patient disclosure form seeks information from you that we must consider before making treatment decisions in the circumstance of the COVID-19 virus. Please disclose to us any condition that compromises your immune system and understand that we may ask you to consider rescheduling treatment after discussing any such condition with us.