Screening Questionnaire

Patient Name: _______________________

Date: _______________________

	Question			
1.	Do you have a fever or above normal temperature?	YES	or	NO
2.	Do you have a dry cough?	YES	or	NO
3.	Do you have a runny nose?	YES	or	NO
4.	Have you recently lost or had a reduction I your sense in taste and smell?	YES	or	NO
5.	Do you have sore throat?	YES	or	NO
6.	Have you been in contact with some who tested positive for COVID 19?	YES	or	NO
7.	Have you been tested for COVID 19 and are awaiting results?	YES	or	NO
8.	Have you followed social distancing guidelines during the stay at home order?	YES	or	NO
9.	Have you traveled outside the United States by air or cruise in the past 14 days?	YES	or	NO
10.	Have you traveled within the United States by air, bus, or train in the past 14 days?	YES	or	NO

I certify that all the above answers are true to the best of my knowledge.

Patient/Guardian Signature: _______________________

-- FOR OFFICE USE --

Recorded TEMP: _______________________

Dental Assistant: _______________________