COVID-19 pre-appointment Screening

Patient Name: Birth Date: Date Created:

	YES	NO
Do you have fever, or have you recently had fever (14-21 days)?		
Are you having shortness of breath or other difficulties breathing?		
Do you have a cough?		
Any other flu-like symptoms such as gastrointestinal upset, headache, or fatigue?		
Have you experienced recent loss of taste or smell?		
Are you or have you been in contact with any confirmed COVID-19 positive patients during the past 15 days?		

If yes, why?

Patients who are well but have a sick family member at home with COVID-19 should consider postponing elective treatment(s).

Do you have heart disease, lung disease, kidney disease, diabetes, or any autoimmune disorders?		
Have you traveled in the past 14 days to any regions affected by COVID-19?		