Patient Screening Form

Patient Name: Testing Format

	PRE-APPOINTMENT	IN-OFFICE
	Date: 05/16/2020	Date:
Do you have fever or have you felt hot or feverish (14-21 days)?	☑ Yes ☐ No	☐ Yes ☐ No
Are you having shortness of breath or other difficulties breathing?	☐ Yes ☑ No	☐ Yes ☐ No
Do you have a cough?	☑ Yes ☐ No	☐ Yes ☐ No
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	☐ Yes ☑ No	☐ Yes ☐ No
Have you experienced recent loss of taste or smell?	☑ Yes ☐ No	☐ Yes ☐ No
Are you in contact with any confirmed COVID-19 positive patients? *Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.*	☐ Yes ☑ No	☐ Yes ☐ No
Is your age over 60?	☑ Yes ☐ No	☐ Yes ☐ No
Do you have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	☐ Yes ☑ No	☐ Yes ☐ No
Have you traveled in the past 14 days to any regions affected by COVID-19?	☑ Yes ☐ No	☐ Yes ☐ No