****

**Patient Name:** %NAME%

|  | PRE-APPOINTMENT | IN-OFFICE |
| --- | --- | --- |
|  | Date: %DATE% | Date: |
| Do you have fever or have you felt hot or feverish (14-21 days)? | %val1% | 𝤿 Yes 𝤿 No |
| Are you having shortness of breath or other difficulties breathing? | %val2% | 𝤿 Yes 𝤿 No |
| Do you have a cough? | %val3% | 𝤿 Yes 𝤿 No |
| Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue? | %val4% | 𝤿 Yes 𝤿 No |
| Have you experienced recent loss of taste or smell? | %val5% | 𝤿 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.* | %val6% | 𝤿 Yes 𝤿 No |
| Is your age over 60? | %val7% | 𝤿 Yes 𝤿 No |
| Do you have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders? | %val8% | 𝤿 Yes 𝤿 No |
| Have you traveled out of the state or to any regions affected  by COVID-19 in the past 14 days? | %val9% | 𝤿 Yes 𝤿 No |

\*If you experience any COVID-19 symptoms in the next 14 days, please call the office to let us know.\*

**I am aware that there is a risk associated with obtaining treatment at this time** %CONSENT% .