Renew 32 COVID- 19 Screening Form

Patient Name:	Pre-Appt Date:	In- Office Date:

Do you have fever or felt hot or feverish recently (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**
Have you been in contact with any confirmed COVID-19 positive patients?	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**
Is your age 60 or over?	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**
Do you have heart disease, lung disease, kidney disease, diabetes, or any other auto-immune disorders?	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**
Have you traveled in the past 14 days?	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**
Have you received the COVID-19 Vaccine? If so, when?	☐ **Yes** ☐ **No** ☐ _____	☐ **Yes** ☐ **No** ☐ _____

Positive responses to any of these would likely indicate a deeper discussion with the dentist before proceeding with dental treatment.