Newton Dental
General & Cosmetic dentistry

COVID-19 SCREENING QUESTIONNAIRE

1. Do you currently have a fever or have felt feverish in the last 14-21 days? Y N

2. Do you have difficulty in breathing of shortness of breath? Y N

3. Do you have any other flu like symptoms or a gastrointestinal upset, headache or fatigue? Y N

4. Do you have a cough? Y N

5. Have you experienced recent loss of taste or smell? Y N

6. Are you in contact with any current COVID-19 positive patient? Y N

Patients who are well but who have a sick family member at home with COVID-19 or has been in contact with someone with COVID-19 should consider postponing treatment.

7. Do you have a heart disease, kidney disease, lung disease, diabetes or any autoimmune disorder? Y N

8. Are you 60 or older? Y N

9. Have you travelled out of the state in the last 14 days? Y N

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

Name:_____Date:_____

Signature:_____