Patient Screening Form

Patient Name: _____ Date of Birth: _____

	Date:	**Date:**
Do you/they have fever, or have you/they felt hot or feverish recently (within 30 days)?	YES ☐ NO ☐	
Are you/they having shortness of breath or other difficulties breathing?	YES ☐ NO ☐	
Do you/they have a cough?	YES ☐ NO ☐	
Any other flu-like symptoms, such as gastrointestinal upset, headache, fatigue?	YES ☐ NO ☐	
Have you/they experienced recent loss of taste or smell?	YES ☐ NO ☐	
Are you/they 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 ☐	
Is your/their age over 60?	YES ☐ NO ☐	
Do you/they have heart disease, lung disease, kidney disease, diabetes, or any auto-immune disorders?	YES ☐ NO ☐	
Have you/they traveled in the past 14 days to any regions affected by COVID-19? (as relevant to your location)	YES ☐ NO ☐	

Temperature: _____ Date: _____ Time: _____