Patient COVID-19 Screening

Patient Name: _____ Date: _____

	Yes	No
Do you have fever, or have you felt hot or feverish recently? (14 – 21 days)		
Are you having shortness of breath or other difficulties breathing?		
Do you have a cough?		
Any other flu-like symptoms? (Gastrointestinal upset, headache, fatigue)		
Have you experienced a recent lost of taste or smell?		
Are you or have been in contact with any confirmed COVID-19 positive patients?		
Are you over the age of 60?		
Do you have any heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?		
Have you traveled in the past 14 days to any regions affected by COVID-19?		

If you answered yes to any of the questions above, please explain in detail below:

By signing below, I certify all information is true and correct to the best of my knowledge.

Signature: _____ **Date:** _____

Please email (calvinwhitedds@gmail.com) OR fax (757-898-1432) 48 hours prior to your appointment.