COVID-19 DENTAL SCREENING QUESTIONNAIRE

Name : _____

Gender : ☐ Male ☐ Female Age : _____

Address : _____

Contact No : _____

Body Temp : _____

Please answer the following:	YES	NO
1. Have you visited any affected geographic area or country within the **last 30 days** prior to your scheduled appointment: If **YES**, what country? _____ If **NO**, have you been in close contact with someone who arrived from abroad?		
2. Have you attended a **mass gathering**, **reunion with relatives or friends**, or **parties** within a month prior to your visit?		
3. Have you been in close contact with a COVID-19 **positive** patient?		
4. Have you been in close contact with a **Person Under Investigation** (**PUI**)?		
5. Have you been in close contact with a **Person Under Monitoring** (**PUM**)?		
6. Do you have any flu-like or respiratory symptoms (*e.g.*, **fever**, **cough**, **runny nose**, **sore throat**, **headache**, **shortness of breath**, **chills**, **general malaise**, **diarrhea**)?		
7. Is there anything else we should know before treating you?		
8. Are you currently experiencing a **DENTAL EMERGENCY**?		

I hereby declare that the above statements are **true**, **accurate** and **complete**.

Signature: .....

Sign over printed name

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