

Dr. Lauren A Adams, DDS Covid-19 Screening Form



Patient Name: _____

	PRE-APPOINTMENT	IN-OFFICE
	Date:	Date:
Do you/they have fever or have you/they felt hot or feverish recently (14-21 days)?	___ Yes ___ No	___ Yes ___ No
Are you/they having shortness of breath or other difficulties breathing?	___ Yes ___ No	___ Yes ___ No
Do you/they 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/they experienced recent loss of taste or smell?	___ Yes ___ No	___ Yes ___ No
Are you/they in contact with any confirmed COVID-19 positive patients? <i>Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.</i>	___ Yes ___ No	___ Yes ___ No
Is your/their age over 60?	___ Yes ___ No	___ Yes ___ No
Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	___ Yes ___ No	___ 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	___ Yes ___ No

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