COVID Screening Form
(Please initial after each question)

Temp:_____

1) Have you had any of the symptoms of COVID-19 that include fever, headaches, cough, shortness of breath, loss of smell and taste?

- ❑ Yes
- ❑ No

If yes, how long ago?_____

2) Have you been around any individual who has had these symptoms or tested positive for COVID?

- ❑ Yes
- ❑ No

If so, how long has it been since you have been in contact with them?

_____

3) Have you been practicing “social distancing” of 6 feet or more?

- ❑ Yes
- ❑ No

4) Do you stay/work from home?

- ❑ Yes
- ❑ No

For how long?_____

5) In the past 2 weeks have you been in any group setting of 2+ individuals or more?

- ❑ Yes
- ❑ No

If Yes explain:_____

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6) Have you traveled outside of your home in the last two weeks?

- ❑ Yes
- ❑ No

If Yes, where:_____

7) Do you wear a facemask when traveling, around people, going to the store, etc?

- ❑ Yes
- ❑ No

8) Have you taken precautions including regular handwashing and avoiding hand shaking?

- ❑ Yes
- ❑ No

9) Have you had the COVID virus?

- ❑ Yes
- ❑ No

If yes, have you been tested twice to confirm you are now free of the virus?

- ❑ Yes
- ❑ No
- ❑ N/A

10) If you have had COVID, and not tested twice, have you had an antibody test?

- ❑ Yes
- ❑ No

if yes, what were the results? _____

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11) Is your employment considered high risk for COVID-19?

- ❑ Yes (medical,dental,hairstylist/salon, other)
- ❑ No

if yes, explain:_____

12) Have you had a COVID-19 vaccination?

- ❑ Yes: Single Dose
- ❑ Yes: Dose 1+2
- ❑ No

if yes, when +what vaccination? _____

13) Have you completed a new medical history form including updated medication list and allergies?

- ❑ Yes
- ❑ No

(If no, visit valentinedentalcare.com, click under New patients, download and complete- then return form to office)

Patient Signature:_____

Date:_____

Witness:_____