DUHON
FAMILY DENTISTRY

COVID -19 PATIENT SCREENING

Name: _____ Date of Birth: _____

Do you have a cough?

☐ Yes ☐ No

Do you have any flu-like symptoms, such as gastrointestinal upset, headache or fatigue?

☐ Yes ☐ No

Have you experienced recent loss of taste or smell?

☐ Yes ☐ No

Have you had any contact with any confirmed COVID-19 positive patients?

☐ Yes ☐ No

Is your age over 60?

☐ Yes ☐ No

Do you have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?

☐ Yes ☐ No

Have you traveled in the past 14 days to any regions affected by COVID-19?

☐ Yes ☐ No

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☐ Yes ☐ No

Signature: _____ Date: _____

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