WESTSIDE DENTAL
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CORONAVIRUS SCREENING QUESTIONNAIRE

Date: Temperature:

Name:
First Last

Date of Birth: / / (MM/DD/YYYY)

Please circle Yes or No for the following questions:

1.	Do you/they have fever or have you/they felt hot or feverish recently (14-21 days)?	YES	NO
2.	Are you/they having shortness of breath or other difficulties breathing?	YES	NO
3.	Do you/they have a cough?	YES	NO
4.	Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	YES	NO
5.	Have you/they experienced recent loss of taste or smell?	YES	NO
6.	Are you/they in contact with any confirmed COVID-19 positive patients?	YES	NO
7.	Is your/their age over 60?	YES	NO
8.	Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	YES	NO
9.	Have you/they been tested positive for COVID-19?	YES	NO
10.	Have you/they traveled in the past 14 days outside your/their state of residence?	YES	NO

Patients who are well but have a sick family member at home with COVID-19 should consider postponing/rescheduling elective treatment. Positive responses to any of these would likely indicate a deeper discussion with the dentist before proceeding with dental treatment.

Patient or Legal Guardian Signature