COVID-19 PATIENT SCREENING FORM

Rock Ridge Family Dentistry
Jeremy T. Louk DMD

Patient Name:

	PRE-APPT	IN-OFFICE
Do you have a fever or have you felt hot or feverish recently (14-21 days)?	Y N	Y N
Are you having shortness of breath or other difficulties breathing?	Y N	Y N
Do you have a cough?	Y N	Y N
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	Y N	Y N
Have you experienced recent loss of taste or smell?	Y N	Y N
Are you in contact with any confirmed COVID-19 positive patients?	Y N	Y N
Is your age over 60?	Y N	Y N
Do you have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	Y N	Y N
Have you traveled in the past 14 days to any regions affected by COVID-19?	Y N	Y N

Patient signature Date

Doctor signature Date