Patient Screening Form

Patient Name

	Pre-Appointment		In-Office	
	Date		Date	
PATIENT SCREENING				
Have you/they recently been vaccinated for COVID-19?	Yes	No	Yes	No
Have you/they recently received a booster shot for COVID-19?	Yes	No	Yes	No
If yes, when was your/their last shot? Which vaccination did you/they receive?				
Have you/they recently been tested for COVID-19?	Yes	No	Yes	No
If yes, please specify test date				
Have you/they tested positive for COVID-19?	Yes	No	Yes	No
If yes, please specify the date of your/their positive test result.				
Within the past 14 days, have you/they had a known exposure to any individual suspected or confirmed to have COVID-19 or who has traveled to a location after which self-quarantine is recommended? *Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.*	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 disorder?	Yes	No	Yes	No
WITHIN THE PAST 24 HOURS, HAVE YOU/THEY HAD ANY OF THE FOLLOWING SYMPTOMS?				
Fever or chills	Yes	No	Yes	No
Cough	Yes	No	Yes	No
Shortness of breath or difficulty breathing	Yes	No	Yes	No
Fatigue	Yes	No	Yes	No
Muscle or body aches	Yes	No	Yes	No
Headaches	Yes	No	Yes	No
New loss of taste or smell	Yes	No	Yes	No
Sore throat	Yes	No	Yes	No
Congestion or runny nose	Yes	No	Yes	No
Nausea or vomiting	Yes	No	Yes	No
Diarrhea	Yes	No	Yes	No

SIGNATURE

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

☐ I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my doctor and their staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of their staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Name of Patient/Legal Guardian

Signature of Patient/Legal Guardian Date