ADA COVID PATIENT SCREENING FORM

PATIENT DETAILS

First Name: _____Last Name: _____Middle Initial: _____

Date of Birth: _____ Today's Date: _____

ADA COVID PATIENT SCREENING FORM

(Circle Yes or No)

Do you/they have fever or have you/they felt hot or feverish recently (14-21 days)? : Yes No

Are you/they having shortness of breath or other difficulties breathing? : Yes No

Do you/they have a cough? : Yes No

Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue? : Yes No

Have you/they experienced recent loss of taste or smell? : Yes No

Are you/they in contact with any confirmed COVID-19 positive patients? Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment. : Yes No

Is your/their age over 60? : Yes No

Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders? : Yes No

Have you/they traveled in the past 14 days to any regions affected by COVID-19? (as relevant to your location): Yes No

Parent/Guardian Name (Print): _____

Parent/Guardian Name (Signature): _____