LEADING EDGE DENTAL CENTER

COVID-19 PATIENT SCREENING QUESTIONAIRE

Patient's Name: ___________________________ Date: ________________ Temp: _________

YES or NO

Do you have a fever or have you felt feverish in the last 14-21 days?

Do you have a dry cough?

Do you currently have other flu-like symptoms??

Have you lost or had a reduction in your sense of taste or smell?

Have you been in contact with someone who has COVID-19 or has tested positive within the last week?

Have you been fully vaccinated? Both doses ☐ J&J Single Dose ☐ NO

Have you HAD Covid 19? Yes ☐ No ☐

Have you tested positive for COVID-19 within the last 14 days?

Have you or anyone living with you traveled **TO OR FROM** a high-risk area by air, bus or train within the past 14 days?

Do you have any heart disease, lung disease, kidney disease, diabetes, or autoimmune disorder?