

# Haller Lake Dentistry

## Screening Questionnaire COVID-19

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Instructions: Please complete the questions below to the best of your ability and return to our office no later than 2 days prior to your dental appointment when possible. Our dental team will enter this information into your chart and ask you to update this information at each visit or as frequently as necessary. Please contact a staff member if you have any questions/concerns.

Do you have any of the following symptoms?

Symptoms Present?

	Yes	No	Unk
Cough (new onset or worsening of chronic cough)	Yes	No	Unk
Shortness of breath or chest pain/tightening	Yes	No	Unk
Fever >100.4F (38C)	Yes	No	Unk
Chills	Yes	No	Unk
Muscle aches	Yes	No	Unk
Runny nose	Yes	No	Unk
Sore throat	Yes	No	Unk
Nausea or vomiting	Yes	No	Unk
Headache	Yes	No	Unk
Abdominal pain	Yes	No	Unk
Diarrhea (≥ loose/looser than normal stools/24hr period)	Yes	No	Unk

1). Have you traveled outside the US in the last 30 days?      Yes    No

2). Have you had direct contact with someone suspected to have the coronavirus (COVID-19 disease)?      Yes    No

3). Have you tested positive for the coronavirus (COVID-19 disease)?      Yes    No

Date of test: \_\_\_\_\_

Facility and location of test: \_\_\_\_\_

4). Are you over the age of 60?    Yes    No

5). Do you have an underlying health condition such as diabetes, heart disease, cancer, asthma?      Yes    No