Patient Pre-Screening Form

Patient Name: _____

	Pre-appointment Date:
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 or 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**