Patient Screening Form – Temple City Dental Care

Forehead temperature reading: ________

Patient Name (First/Last): ____

Question	Response
In the past 14-21 days, have you had a fever (greater than 100.4ºF) or felt hot or feverish?	☐ **Yes** ☐ **No**
Are you having or have you experienced any recent shortness of breath or other difficulties breathing?	☐ **Yes** ☐ **No**
Do you currently have a cough?	☐ **Yes** ☐ **No**
Have you experienced any other flu-like symptoms, such as gastrointestinal upset (stomachache), headache, or fatigue?	☐ **Yes** ☐ **No**
Have you experienced any recent loss of taste or smell?	☐ **Yes** ☐ **No**
Have you experienced any recent nausea, vomiting, or diarrhea?	☐ **Yes** ☐ **No**
Are you in contact with any confirmed or presumed COVID-19 positive patients?	☐ **Yes** ☐ **No**
Have you traveled in the past 14 days to any regions affected by COVID-19?	☐ **Yes** ☐ **No**
Are you over the age of 60?	☐ **Yes** ☐ **No**
Do you have heart disease, lung disease, kidney disease, diabetes, or any auto-immune disorders?	☐ **Yes** ☐ **No**

Patient Signature: ______________________________ Date: _________________