



Patient Screening Form (Regarding COVID-19 Risk)

Patient Name:	Pre-Appointment	In-Office
	Date:	Date:
Do you have fever or have you felt hot or feverish recently (14-21 days)?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Are you having shortness of breath or other difficulties breathing?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Do you have a cough?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Have you experienced recent loss of taste or smell?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Are you in contact with any confirmed COVID-19 (+) patients? Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Is your age over 60?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Do you have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Have you traveled in the past 14 days to any regions affected by COVID-19? (as relevant to your location)	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

Positive responses to any of these questions would likely indicate a deeper discussion with Dr. Parham before proceeding with elective dental treatment.