James D. Sanderson, DDS

Creating Beautiful Smiles

Patient Name_____ Date_____

1) Do you have a fever, or have you felt hot or feverish recently?
    a. ____Yes ____No
2) Are you having shortness of breath or other difficulties breathing?
    a. ____Yes ____No
3) Do you have a cough?
    a. ____Yes ____No
4) Any other flu-like symptoms, such as stomach issues, headache, or fatigue?
    a. ____Yes ____No
5) Have you experienced recent loss of taste or smell?
    a. ____Yes ____No
6) Are you in contact with any confirmed or suspected COVID-19 positive patients?
    a. ____Yes ____No
7) Have you been tested for COVID-19 recently?
    a. ____Yes ____No
8) Have you traveled in the past 14 days?
    a. ____Yes ____No