

Patient Screening Form

Patient Name:

	Date:
Do you have fever, or have you felt hot or feverish recently (14-21 days)?	<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
Do you have a cough?	<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
Have you experienced recent loss of taste or smell?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you in contact with any confirmed COVID-19 positive patients? <i>Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is your age over 60?	<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
Have you traveled in the past 14 days to any regions affected by COVID-19?	<input type="checkbox"/> Yes <input type="checkbox"/> No