**Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |
| --- | --- |
| Do you have a fever, or have you felt hot or feverish recently? | \_\_\_\_ Yes \_\_\_\_ No |
| Are you having shortness of breath or other difficulties breathing? | \_\_\_\_ Yes \_\_\_\_ No |
| Do you have a cough that is not related to allergies? | \_\_\_\_ Yes \_\_\_\_ No |
| Any flu-like symptoms, such as GI upset, headache or fatigue? | \_\_\_\_ Yes \_\_\_\_ No |
| Have you recently experienced loss of taste or smell? | \_\_\_\_ Yes \_\_\_\_ No |
| Are you in contact with any confirmed COVID-19 positive patients? | \_\_\_\_ Yes \_\_\_\_ No |
| Are you immuno-compromised in any way? | \_\_\_\_ Yes \_\_\_\_ No |
| Have you traveled in the past 14 days to regions heavily affected by COVID-19 | \_\_\_\_ Yes \_\_\_\_ No |

**Positive responses to any of these would likely indicate a deeper discussion with the dentist before proceeding with elective dental treatment.**

* For testing, see the list of [State and Territorial Health Department Websites](https://www.cdc.gov/publichealthgateway/healthdirectories/healthdepartments.html) for your specific area’s information.