DESERT HILLS
Cosmetic · Family · Implant · Sleep Apnea
DENTAL CARE

**COVID-19 Pre-Screening Questionnaire**

**Please disclose any indication of having been exposed to COVID-19, or whether you have experienced any signs or symptoms associated with the COVID-19 virus.**

Patient Name:_____Date of Birth:_____

Temperature at check-in:_____ (to be completed by DHDC staff member)

Do you have a fever or have you felt hot or feverish recently (14-21 days)? Yes __No__

Do you have chills or repeated shaking with chills? Yes__No__

Are you having shortness of breath or other difficulties breathing? Yes__No__

Do you have a cough? Yes__No__

Do you have a runny nose? Yes__No__

Have you recently lost or had a reduction in your sense of smell? Yes__No__

Do you have a sore throat? Yes__No__

Any other flu-like symptoms, such as gastrointestinal upset, headache, muscle pain or fatigue? Yes__No__

Are you in contact with any confirmed COVID-19 positive patients? Yes__No__

Have you tested positive for COVID-19? Yes__No__

Have you been tested for COVID-19 and are awaiting results? Yes__No__

Are you over the age of 65? Yes__No__

Do you have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders? Yes__No__

Have you traveled by air, bus, train or ship within the past 14 days? Yes__No__

**By signing this document, I acknowledge that the answers I have provided above are true and accurate.**

**Signature_____Date_____**