**The Manato Family Dentistry, LLC**

COVID-19 Patient Screening Form

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| **Patient Name:** | **Before Appointment** | I**n-Office Appointment** |
| **Are you over 60 years of age?** | **YES/NO** | **YES/NO** |
| **Do you have preexisting condition such as lung disease, heart disease, diabetes, kidney disease or an autoimmune disorder?** | **YES/NO** | **YES/NO** |
| **Are you experiencing shortness of breath or trouble breathing?** | **YES/NO** | **YES/NO** |
| **Do you have a temperature of 100.4° F or higher?** | **YES/NO** | **YES/NO** |
| **Are you experiencing a sore throat?** | **YES/NO** | **YES/NO** |
| **Are you coughing?** | **YES/NO** | **YES/NO** |
| **Are you experiencing repeated shaking or chills?** | **YES/NO** | **YES/NO** |
| **Do you have muscle aches?** | **YES/NO** | **YES/NO** |
| **Are you experiencing gastrointestinal changes?** | **YES/NO** | **YES/NO** |
| **Have you noticed loss of smell or taste?** | **YES/NO** | **YES/NO** |
| **Have you had contact with a known or suspected COVID-19 positive person?** | **YES/NO** | **YES/NO** |
| **In the last 14 days, have you traveled to an area that has a high incidence of COVID-19?** | **YES/NO** | **YESNO** |
| **If yes to the question above, please specify:** | | |