**COVID-19 PATIENT HEALTH QUESTIONNAIRE**

This patient questionnaire form seeks information from you that we must consider before making any treatment decisions. We will require you to complete this questionnaire prior to every visit with our office. Please clearly mark your answer in either the YES or NO column.

|  |  |  |
| --- | --- | --- |
|  | YES | NO |
| At this time, do you have a fever or above normal temperature? |  |  |
| Have you experienced shortness of breath or had trouble  breathing? |  |  |
| Do you have a dry cough? |  |  |
| Do you have a runny nose? |  |  |
| Have you recently lost or had a reduction in your sense of  smell? |  |  |
| Do you have a sore throat? |  |  |
| Have you been in contact with someone who has tested  positive for COVID-19? |  |  |
| Have you tested positive for COVID-19? |  |  |
| Have you been tested for COVID-19 and are awaiting results? |  |  |
| Have you traveled outside the United States by air or cruise  ship in the past 14 days? |  |  |
| Have you traveled within the United States by air, bus or train within the past 14 days? |  |  |

By my signature, I acknowledge that all of my answers as marked above are both true and accurate.

\_\_\_

Printed Patient Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient or Parent/Guardian Signature Date

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Witness-Lee Dentistry Employee Date