dentalessence

COVID-19 Screening Questionnaire

To prevent the spread of COVID-19 and reduce the potential risk of exposure to our staff and patients, we are conducting a simple screening questionnaire. Your participation is important to help us take precautionary measures to protect you and everyone in this building. Thank you for your time.

Patient Name:	**Phone number:**

	Self-Declaration by Patient
1.	**Have you or have you been in contact with anyone who has been diagnosed with Coronavirus in the last 14 days?** Yes ☐ No ☐
2.	**Have you been in contact with anyone who has Self Isolated in the last 14 Days?** Yes ☐ No ☐
3.	**Have you experienced any cold or flu-like symptoms in the last 14 days including:** **Do you have a new continuous cough?** Yes ☐ No ☐ **Have you become breathless, or are you more breathless than usual? Do you struggle to breathe?** Yes ☐ No ☐ **Do you have a high temperature (fever)? If you don't have a thermometer do you feel hot to touch on your chest or back?** Yes ☐ No ☐ **A sore throat, a tacky throat or soreness when swallowing food?** Yes ☐ No ☐ **Have you experienced loss of taste and smell?** Yes ☐ No ☐ **Are you too ill to do your usual daily activities?** Yes ☐ No ☐ **Are you feeling more confused than normal?** Yes ☐ No ☐
4.	**Are you 70 OR OLDER with Cardiac Problems or Respiratory Problems or Diabetes?** Yes ☐ No ☐
5.	**Have you been advised that you need to be shielded?** Yes ☐ No ☐

Signed: X	**Date:**

If the answer to any of these questions is **YES** then unfortunately, we will be unable to see you for your appointment today.

If the answer to any of these is **NO** then you can proceed to coming in for your appointment,
Please be advised that we will complete a temperature check when you arrive at the practice.

Thank you.