Ambulatory Dental Anesthesia Associates
VIGILANT

Dedicated to make the dental experience for your patients, comfortable and anxiety free, since 1978

COVID-19 History and Symptoms Questionnaire

Dear Patient:

In order to reduce the risk of spreading COVID-19, we have asked you a number of "screening" questions below. For the safety of our staff, other patients, and yourself, please be truthful and candid in your answers.

- What was your temperature this morning? _____ (° F / ° C)
- Have you or anyone accompanying you been diagnosed with COVID-19 in the last 14 days? _____ YES _____ NO
- Are you or anyone accompanying you currently awaiting the results of a COVID-19 test? _____ YES _____ NO
- Do you or anyone accompanying you currently have, or in the last 14 days have had any of the following symptoms?
  - Fever _____ YES _____ NO
  - Dry cough _____ YES _____ NO
  - Loss of taste and/or smell _____ YES _____ NO
  - Flu-like symptoms _____ YES _____ NO
  - Difficulty breathing or shortness of breath _____ YES _____ NO
  - Fatigue or body aches _____ YES _____ NO
  - Chest pain _____ YES _____ NO
- In the last 14 days have you or anyone accompanying you traveled anywhere within or outside of the United States? _____ YES _____ NO
  If so, where? _____

I have carefully reviewed all of the questions herein, and attest that the answers represented above are true and correct to the best of my knowledge.

Name _____

Signature _____ Date _____

------- **STAFF USE ONLY** -------

Temperature Upon Entry: _____ (° F / ° C)

Updated 5/14/2020