# STRATFORD DENTAL

## Covid-19 Screener

Please complete this screener and bring it with you to your next appointment.
If you answer yes to any of these questions on the day of your appointment, please call for further instructions and to reschedule your appointment.

| | | |
|---|---|---|
| Have you been diagnosed with Covid-19? | ___Yes | ___NO |
| Are you waiting the results of a Covid-19 test? | ___Yes | ___NO |
| Have you been exposed to someone diagnosed with Covid-19? | ___Yes | ___NO |
| Do you have any shortness of breath, difficulty breathing or pain in your chest not casued by any underlying medical condition? | ___Yes | ___NO |
| Have you recently lost your sense of taste and/or smell? | ___Yes | ___NO |
| Do you have any new confusion or inability to arouse? | ___Yes | ___NO |
| Do you have bluish lips or face? | ___Yes | ___NO |
| Do you have a fever of 100.4 or greater, or are you taking any medicaiton for a fever? | ___Yes | ___NO |
| Do you have chills or repeated shaking with chills? | ___Yes | ___NO |
| Do you have any muscle pain not associated with strain or overuse? | ___Yes | ___NO |
| Do you have a dry cough not casued by any underlying medical condition? | ___Yes | ___NO |
| Do you have a sore throat? | ___Yes | ___NO |
| Do you have sneezing, watery eyes, and/or sinus pain/pressure that is unusual for you and not related to seasonal allergies? | ___Yes | ___NO |
| Have you experienced headaches, fatigue or weakness not casued by any underlying medical condition? | ___Yes | ___NO |

_____ _____

Patient name Name of responsible party (if applicable)

_____ _____ _____

Signature Signature Date