Falls Church Dental Care

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COVID-19 Patient Screening Form

Patient Name:		Before Appointment	In-Office Appointment
1	Are you over 60 years of age?	☐ Yes ☐ No	☐ Yes ☐ No
2	Do you have a preexisting condition such as lung disease, heart disease, diabetes, kidney disease or an autoimmune disorder?	☐ Yes ☐ No	☐ Yes ☐ No
3	Are you experiencing shortness of breath or trouble breathing?	☐ Yes ☐ No	☐ Yes ☐ No
4	Do you have a temperature of 100.4° F or higher?	☐ Yes ☐ No	☐ Yes ☐ No
5	Are you experiencing a sore throat?	☐ Yes ☐ No	☐ Yes ☐ No
6	Are you coughing?	☐ Yes ☐ No	☐ Yes ☐ No
7	Are you experiencing repeated shaking with chills?	☐ Yes ☐ No	☐ Yes ☐ No
8	Do you have muscle aches?	☐ Yes ☐ No	☐ Yes ☐ No
9	Are you experiencing gastrointestinal changes?	☐ Yes ☐ No	☐ Yes ☐ No
10	Have you noticed a loss of smell or taste?	☐ Yes ☐ No	☐ Yes ☐ No
11	Have you had contact with a known or suspected COVID-19-positive person?	☐ Yes ☐ No	☐ Yes ☐ No
12	In the last 14 days, have you traveled to an area that has a high incidence of COVID-19?	☐ Yes ☐ No	☐ Yes ☐ No
If you answered yes to any of the above questions, please specify:			

Reset Form