ENDODONTIC ASSOCIATES

COVID-19 Patient Screening Questions

(required by Oklahoma Board of Dentistry)

Y	N	
☐	☐	Do you have a fever or have you experienced a fever within the past 14 days?
☐	☐	Does anyone close to you have a fever or have they experienced a fever in the past 14 days?
☐	☐	Have you or anyone close to you experienced a recent onset of respiratory problems, such as a cough or difficulty in breathing within the past 14 days?
☐	☐	Have you or anyone close to you experienced flu-like symptoms within the past 14 days such as: a. Cough – wet or dry b. Fever c. Shortness of Breath d. Sore Throat e. Muscle/Body Aches f. Nausea/Vomiting g. Fatigue h. A recent lack of taste or smell
☐	☐	Have you, or anyone you have come into contact with, travelled out of state within the last 14 days?
☐	☐	Have you, or anyone you have come into contact with, travelled outside of the country in the last 21 days?
☐	☐	Have you come into contact with anyone who has tested positive for COVID-19?
☐	☐	Have you been tested for COVID-19, with either a positive or negative result?
☐	☐	Do you have an autoimmune disorder or are you on an immune suppressing medication or steroids?
☐	☐	Have you been diagnosed or treated for a heart or lung related disease within the past 12 months?
☐	☐	Have you been diagnosed or treated for cancer in the past 12 months?
☐	☐	Do you currently smoke or vape or have you stopped those activities within the past 2 years?
□	□	Are you Diabetic?

Patient Name: _____

Signature:_____

Date:_____