University Oral Surgery Center
COVID-19 Patient Screening form

Patient's Name: _____ Date:_____

Due to the ongoing pandemic, we are required to pre-screen patients before we make an appointment. Please answer the following questions, as they relate to the patient planning to schedule an appointment with our office:

In the past 21 days, has the patient had, is he the patient now experiencing:

Fever or feeling hot/feverish	___Yes	___No
Shortness of breath or difficulty breathing	___Yes	___No
Cough	___Yes	___No
Flu-like symptoms, fatigue, body ache	___Yes	___No
Loss of taste or smell	___Yes	___No
Sore throat	___Yes	___No

Has the patient tested positive for COVID-19?
___Yes ___No

Has the patient been in contact with a confirmed COVD-19 positive individual?
___Yes ___No

Is patient 60 years old or older?
___Yes ___No

Does the patient have, or has he/she been diagnosed with:

Heart disease	___Yes	___No
Lung disease such as asthma, COPD, lung transplant	___Yes	___No
Kidney disease such as renal failure, kidney transplant	___Yes	___No
Diabetes	___Yes	___No
Auto-immune disorder such as lupus, inflammatory bowel disease	___Yes	___No

If the answer to any of the above questions is yes, we may need to postpone any appointment pending further evaluation and resolution of medical issue.
For COVID testing, please refer to your State and Territorial Health Department.

Patient / legal guardian's Signature:_____ Date:_____

Doctor's Signature: _____ Date: _____