Supplemental Health Questionnaire

This health questionnaire seeks information from you that we must consider before making treatment decisions. It is important that you disclose to this office any indication of having been exposed to COVID-19 or whether you have experienced any signs or symptoms associated with the COVID-19 virus.

Patient Name:

	Yes	No
Do you or the person accompanying you have a fever or feel feverish?	☐	☐
Are you or the person accompanying you experiencing shortness of breath or having trouble breathing?	☐	☐
Do you or the person accompanying you have a dry cough?	☐	☐
Do you or the person accompanying you have a sore throat?	☐	☐
Have you recently lost or had a reduction in your sense of taste or smell?	☐	☐
Do you or the person accompanying you have a headache, chills or muscle pain?	☐	☐
Even if you don't *currently* have any of the above symptoms, have you experienced **any** of these symptoms in the last 14 days?	☐	☐
Have you been in contact with someone who has tested positive for COVID-19 in the last 14 days?	☐	☐
Have you tested positive for COVID-19?	☐	☐
Have you been tested for COVID-19 and are awaiting results?	☐	☐
Have you or anyone in your household traveled outside the United States in the past 14 days?	☐	☐
Do you have heart disease, lung disease, diabetes or any auto-immune disorder?	☐	☐

I fully understand and acknowledge the above information. By signing this document, I acknowledge that the answers I have provided above are true and accurate.

Signature

Date

Witness