LEPAK FAMILY DENTISTRY CORONA VIRUS (COVID-19) PATIENT QUESTIONNAIRE

The safety and health of our patients, employees and community members remains our overriding priority.

To prevent the spread of COVID-19 and reduce the potential risk of exposure to our employees, patients and their families, we are conducting a simple screening questionnaire. Your participation is important to help us take precautionary measures to protect you, our staff and our community.

Patient Name: Date of Birth:

1. Have you travelled to any locations of COVID-19 outbreak in the past 14 days? ◯ YES ◯ NO

2. Have you had close contact with or cared for someone diagnosed with COVID-19 within the last 14 days? ◯ YES ◯ NO

3. Have you had any of the following symptoms related to COVID-19 within the last 2 weeks: (circle those that apply)

   Cough ☐ Muscle pain ☐ Shortness of breath ☐ Fever ☐ Chills ☐

   Repeated shaking with chills ☐ Muscle pain ☐ Recent GI upset or diarrhea ☐

   Recent onset of headache or sore throat ☐ Difficulty breathing ☐ New loss of taste or smell ☐

If you are experiencing symptoms related to COVID-19 we will reschedule your appointment 2 weeks after symptoms resolve.

4. Have you had the COVID-10 virus? ◯ YES ◯ NO
   If so has it been 4 weeks since your symptoms resolved? ◯ YES ◯ NO
   Were you hospitalized? ◯ YES ◯ NO
   If so, when were you released?_____

5. Are you over the age of 65? ◯ YES ◯ NO

6. Do you have: (circle those that apply)

   Serious Heart Condition ☐ Diabetes ☐ Kidney Disease ☐

   Chronic lung disease or asthma ☐ Autoimmune Disorders ☐

PRINT FORM

Please save or print this form and email it to us.
If you cannot email it, please bring it with you to our office.

Thank you for your cooperation.

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