COVID-19 PATIENT QUESTIONNAIRE

Patient Name: _____

Do you have a preexisting condition such as lung disease, heart, kidney disease?	Yes/No
Do you have an autoimmune disorder?	Yes/No
Are you experiencing shortness of breath or trouble breathing?	Yes/No
Do you have a temperature of 100.4 F or higher?	Yes/No
Are you experiencing a sore throat?	Yes/No
Are you coughing?	Yes/No
Are you experiencing repeated shaking with chills?	Yes/No
Do you have muscle aches?	Yes/No
Are you experiencing gastrointestinal changes?	Yes/No
Have you noticed a loss of smell or taste?	Yes/No
Have you had contact with a known or suspected COVID-19 positive person?	Yes/No
Have you traveled outside of the DC Metro area within the past 14 days?	Yes/No

If you answered yes to any of the questions above, we need to speak with you personally before your appointment! Please call the office at (202) 363-1314 or contact us via our website at www.foresthillsdentaldc.com.

Patient Signature: _____

Date: _____