Today's Date: _____

Patient: _____

DOB: _____

olentangy Orthodontics

COVID-19 Supplemental Health Screening

In the past 14-21 days have you or anyone in your household:

Tested Positive for or been diagnosed as having COVID-19? If yes, when? Date_____	Yes		No	

In the past 2-14 days have you, your child, or other recent acquaintances had:

A fever (defined as above 99.6F), felt hot, feverish, or chills?	Yes		No	
Sore throat?	Yes		No	
Fatigue?	Yes		No	
A cough?	Yes		No	
Shortness of breath or difficulty breathing?	Yes		No	
Persistent pain, pressure, or tightness in the chest?	Yes		No	
Traveled to any regions affected by COVID-19*? Traveled by airplane?	Yes		No	
Stomach upset? Diarrhea?	Yes		No	
Nausea or Vomiting?	Yes		No	
A runny nose or congestion?	Yes		No	
An eye infection or pink eye?	Yes		No	
Loss of smell or taste?	Yes		No	
Muscle or body aches?	Yes		No	

I understand that if the answer to any of these questions is yes, I will be asked to reschedule today's orthodontic appointment.

_____ _____

Patient/Parent's Signature Date