

Today's Date: _____

Patient: _____

DOB: _____



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? Exposed to someone who tested positive? If yes, when? Date _____	Yes		No	
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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 outside of Ohio*? Where? _____ 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