

Supplemental Health Questionnaire

If you have been exposed to a communicable disease such as COVID-19, you may possibly spread the disease to the orthodontist, orthodontic staff or other patients/parents in the practice. Therefore, prior to each appointment, we will be asking the following questions to reduce the chances of transmission

Patient Name: _____	Pre-Appointment Date:	In-Office Date:
Do you/they have fever or have you/they felt hot or feverish recently (within the past 21 days)?	Yes No	Yes No Temp. _____
Are you/they having shortness of breath or other difficulties breathing?	Yes No	Yes No
Do you/they have a cough?	Yes No	Yes No
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	Yes No	Yes No
Have you/they experienced recent loss of taste or smell?	Yes No	Yes No
Have you/they been in contact with any confirmed COVID-19 positive patients? <i>Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.</i>	Yes No	Yes No
Is your/their age over 60?	Yes No	Yes No
Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	Yes No	Yes No
Have you/they traveled in the past 14 days to any regions affected by COVID-19? (as relevant to your location)	Yes No	Yes No

Patient/Parent signature: _____ Date _____