Dental Elements COVID-19 Screening Questionnaire

To prevent the spread of COVID-19 and reduce the potential risk of exposure to our staff and patients, we are conducting a simple screening questionnaire. Your participation is important to help us take precautionary measures to protect you and everyone in this building. Thank you for your time.

Have you or have you been in contact with anyone who has been diagnosed with Coronavirus in the last 14 days?	☐Yes	☐No
Do you have fever or have you/they felt hot or feverish recently (14-21 days)?	☐Yes	☐No
Are you having shortness of breath or other difficulties breathing?	☐Yes	☐No
Do you have a new, continuous cough?	☐Yes	☐No
Does anyone in your household have a new, continuous cough or a high temperature?	☐Yes	☐No
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	☐Yes	☐No
Have you experienced recent loss of taste or smell?	☐Yes	☐No
Are you in contact with any confirmed Covid-19 positive patients?	☐Yes	☐No
Is your age over 70 and do you have cardiac problems or respiratory problems or diabetes?	☐Yes	☐No
Have you been advised that you need to be shielded?	☐Yes	☐No

Signed: X	**Date:**

If the answer to any of these questions is **YES** then unfortunately, we will be unable to see you for your appointment today.

If the answer to any of these is **NO** then you can proceed to coming in for your appointment, Please be advised that we will complete a temperature check when you arrive at the practice.

Thank you.