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SCREENING QUESTIONNAIRE COVID-19

PATIENT IDENTIFICATION :

Surname : Name :
Date of birth : Sex : F M

Place of residence :
City: Postal code :

Number phone : e-mail :

Your medical practitioner's name :

Patient legal care for minor child : Surname : Name :

HEALTH STATUS :

1. Was the patient /were you experiencing any of these symptoms in the past 14 days :

• Fever > 38°, sweats, chills	YES	NO
• Difficulty breathing	YES	NO
• Cough	YES	NO
• Body aches (headache, muscle pain, sore throat)	YES	NO
• Fatigue	YES	NO
• Loss of smell	YES	NO
• Loss of taste	YES	NO
• Vomiting	YES	NO
• Diarrhea	YES	NO

2. Has the patient / Have you been in contact with anyone who had been experiencing the symptoms above in the past 14 days ? YES NO

3. Has the patient / Have you been in close contact with anyone who had confirmed COVID-19 diagnosis in the past 14 days ? YES NO

4. Does the patient has / do you have comorbidities: cardiovacular disease, lung disease, kidney disease, diabetes, hypertension, moderate to severe asthma, immunodeficiency, over 65 years ?
YES Which one? NO

5. I confirm that I am positive for COVID-19. YES NO

6. I confirm that I am waiting for the results of a laboratory test of COVID-19. YES NO

I verify the information I have provided on this screening questionnaire is truthful and accurate.
I knowingly and willingly consent to have today's orthodontic care.

Date : Signature :

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