COVID-19 SCREENING

Sana Dentistry
8-3100 Winston Churchill Blvd, Mississauga ON, L5L2V7
905-607-3330 / SanaDentistry.ca

Name _____ **Date** _____

Have you traveled out of country in the last 14 days?

☐ Yes ☐ No

If '**yes**', where? _____

Have you returned from travel within Canada from **a location severely affected by COVID-19?**

☐ Yes ☐ No

If '**yes**', where? _____

Do you have any of these symptoms:

Dry cough	☐ Yes	☐ No
Shortness of breath	☐ Yes	☐ No
Difficulty breathing	☐ Yes	☐ No
Sore throat	☐ Yes	☐ No
Runny nose	☐ Yes	☐ No

Do you have **a fever or have felt hot or feverish anytime** in the last two weeks?

☐ Yes ☐ No

Patient temperature at appointment: _____

Have you experienced **a recent loss of smell or taste?**

☐ Yes ☐ No

Have you been in contact with any **confirmed COVID-19 positive patients, or persons self-isolating because of a determined risk for COVID-19?**

☐ Yes ☐ No

Have you had any **contact** with anyone who has symptoms of illness who has traveled to an affected area?

☐ Yes ☐ No

Are you over the age of 60?

☐ Yes ☐ No

Do you have any of the following? Heart disease, lung disease, kidney disease, diabetes or any auto-immune disorder?

☐ Yes ☐ No

Signature _____