ENVISION DENTAL

Covid-19 Questionnaire

Do you/have a fever or have you 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 cough? 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

Have you been in contact with anyone that has a confirmed diagnosis of Covid-19? Yes No
(Patients who are well but who have a sick family member at home with Covid-19 should postpone treatment)

Are you over the age of 60? Yes No

Do you have heart disease, lung disease, kidney disease, diabetes or any auto immune disorder? Yes No

Have you traveled in the past 14 days to any regions other than Florida that have been heavily affected by COVID 19? Yes No

Patient Name_____ Date_____

P: 386-256-4786
F: 386-788-7007

870 Dunlawton Avenue, Suite 110
Port Orange, FL 32127

envision.dental@hotmail.com
www.envision-dental.com