PHILIP M. GRAY, DDS
IMPLANT • COSMETIC • RESTORATIVE

COVID-19 Screening Questionnaire

Date:_____________ Patient Temperature: _____________

Have you had a fever over 100.4 in the last 3 weeks?

YES NO

Have you or anyone in your household had a fever and/or symptoms of lower respiratory illness, cough or shortness of breath in the last 14 days?

YES NO

Do you have any other flu like symptoms? Headache, fatigue, GI issues?

YES NO

Have you had loss of taste or smell the last 14 days?

YES NO

Have you or anyone in your household been in close contact with a confirmed covid-19 patient within the last 14 days?

YES NO

Have you traveled in the past 14 days to heavily impacted COVID-19 regions?

YES NO

Patient:______________________

Signature_____________________ Date____________