J Peter St Clair, DMD, PC
COVID-19 Pandemic Period Questionnaire

Patient Name:_____DOB:_____

Today's Date:_____ Appointment Date:_____

1. Has there been any changes in your medical history since your last appointment? **YES NO**
   If yes:_____
2. Have a list of patient's medications ready to review
   List all medication changes here:
   _____
   _____
3. Do you have any of the following:
   - Fever
   - Headache
   - Cough
   - Shortness of Breath
   - Loss of smell or taste
4. Have you been practicing social distancing? **YES NO**
5. Have you been around any individual who has had these symptoms or tested positive for COVID-19? **YES NO**
   - If so, how long has it been since you have had contact with them?_____
6. Have you visited an assisted living, nursing home, hospital, or any place that is treating COVID-19 patients? **YES NO**
7. Have you had the COVID-19 virus? **YES NO**
   - Has a minimum of 72 hours passed since recovery? (resolution of fever without the use of fever reducing medications, and improvement of respiratory symptoms) and at least 7 days passed since your symptoms first occurred? **YES NO** -or-
   - If you had a laboratory confirmed case of COVID-19 but have not had symptoms, has at least 7 days passed since the date of the first positive COVID-19 diagnostic test? **YES NO**
8. Have you had any subsequent illness? **YES NO**

- Information confirmed on day of appointment
- Patient's temperature on day of appointment: _____
- 48-hour patient check