Diana Dizik, DDS

General and Cosmetic Dentistry

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PATIENT QUESTIONNAIRE

Do you have a fever or above-normal temperature (>100.4°F)? Take temperature at appointment.	☐No ☐Yes
Are you experiencing shortness of breath or having trouble breathing?	☐No ☐Yes
Do you have a dry cough?	☐No ☐Yes
Do you have a runny nose?	☐No ☐Yes
Have you recently lost or had a reduction in your sense of smell or taste?	☐No ☐Yes
Do you have a sore throat?	☐No ☐Yes
Are you experiencing chills or repeated shaking with chills?	☐No ☐Yes
Do you have unexplained muscle pain?	☐No ☐Yes
Do you have a headache?	☐No ☐Yes
Even if you don't currently have any of the above symptoms, have you experienced any of these symptoms in the last 14 days?	☐No ☐Yes
Have you been in contact with someone who has tested positive for COVID-19 in the last 14 days?	☐No ☐Yes
Have you been tested for COVID-19 in the last 14 days? If "no", proceed to next question.	☐No ☐Yes
If Yes, what is the result of the testing? **If negative,** proceed to next question. **If still waiting on results,** schedule appointment after results are known.	☐Unsure ☐Positive
Have you traveled more than 100 miles from your home in the last 14 days	☐No ☐Yes