KIOURTSIS ORTHODONTICS

HEALTH QUESTIONNAIRE

Has the patient, anyone living with, working with, or socializing with the patient tested positive for Covid-19, or was diagnosed with Covid-19?

Yes_____ No_____ **If yes, when? Date _____**

Please explain: _____

Has the patient, anyone with the patient, or any of the patient's acquaintances had a Covid-19 test within the past two weeks?

Yes_____ No_____ **If yes, when? Date _____**

Please explain: _____

Do you, your child, or others accompanying you to today's appointment or other recent acquaintances have:

•A Fever (defined as above 99.6 degrees)	Yes_____ No_____
•A Cough?	Yes_____ No_____
•Shortness of Breath and/or Trouble Breathing?	Yes_____ No_____
•Persistent Pain, Pressure, or Tightness in the Chest?	Yes_____ No_____
•Chills, Repeated Shaking with Chills?	Yes_____ No_____
•Muscle Pain?	Yes_____ No_____
•Headache?	Yes_____ No_____
•New Loss of Taste or Smell?	Yes_____ No_____

_____
Patient Name (PRINT)

_____
Parent's Name (PRINT)

_____ _____
Patient's/Parent's Signature Date