Gerard Cuomo
Microscope Enhanced Dentistry

COVID-19 Questionnaire

Patient Name: _____ **Date:** _____

1. Have you been in contact with someone who has tested positive for COVID-19?	YES☐ NO☐
2. Have you tested positive for COVID-19?	YES☐ NO☐
3. Have you been tested and are awaiting results?	YES☐ NO☐
4. Have you traveled outside the United States or to a high-risk area in the past 14 days?	YES☐ NO☐
5. Do you have a fever or above normal temperature?	YES☐ NO☐
6. Have you taken any fever reducing medications, including: Ibuprofen (Advil, Motrin or other), Acetaminophen (Tylenol or other), Naproxen (Aleve or other) or Aspirin in the last 14 days and, if yes, for what reason?	YES☐ NO☐
7. Have you experienced shortness of breath or had trouble breathing?	YES☐ NO☐
8. Do you have a cough?	YES☐ NO☐
9. Do you have a runny nose?	YES☐ NO☐
10. Have you recently lost or had a reduction in your sense of smell?	YES☐ NO☐
11. Do you have a sore throat?	YES☐ NO☐
12. Do you have muscle pain?	YES☐ NO☐
13. Do you have any other FLU like symptoms, such as gastrointestinal upset, headache or fatigue?	YES☐ NO☐
14. Do you have heart disease, lung disease, kidney disease, diabetes or any other auto-immune disorders?	YES☐ NO☐
15. Do you otherwise feel unwell?	YES☐ NO☐

Signature: _____ Date: _____