American Dental Hygienists' Association

ADHA COVID-19 PATIENT SCREENING QUESTIONNAIRE

*Indicate Yes or No and provide relevant comments

Patient Name: _____ Date: _____

Screening Questions	Pre-Appointment*		In-Office*		48- Hours Post-Appointment*	
	yes	no	yes	no	yes	no
Do you have a fever, or have you felt feverish recently?						
Do you have a cough?						
Are you having shortness of breath or any difficulty breathing?						
Do you have chills or repeated shaking with chills?						
Do you have any muscle pain?						
Do you have any recent onset of headache or sore throat?						
Do you have any other flu-like symptoms?						
Do you have any recent loss of taste or smell?						
Have you experienced any recent GI upset or diarrhea?						
Are you in contact with anyone who has been confirmed to be COVID-19 positive?						
Have you traveled in the past 14 days to any regions affected by COVID-19?						
Are you over the age of 65?						
Do you have:						
Heart disease						
Lung disease						
Kidney disease						
Diabetes						
Autoimmune disorders						