Respiratory Illness Signs & Symptoms
COVID-19 (Coronavirus) Screening Form

Patient Name _____ Date of Birth _____

Today's Date _____

All patients of Pettyjohn Family Dentistry are being asked the following questions for the safety of our patients and team members. Please answer the following:

CLINICAL - Please answer YES or NO to the following questions:

1. Do you have a fever (100.4 F or greater)? YES NO
2. Do you have a cough (not related to allergies or COPD)? YES NO
3. Do you have shortness of breath? YES NO

EXPOSURE - Please answer YES or NO to the following questions:

1. Have you been in close contact with any person who may be sick with an influenza-like illness, COVID-19 (Coronavirus), Ebola, Measles, MERS, SARS, or TB? YES NO
2. Within the past 14 days have you had close contact with any person with confirmed COVID-19 (Coronavirus) or who is under investigation for COVID-19 (Coronavirus) ? YES NO
3. Within the past 14 days have you or anyone close to you traveled to China, Iran, Italy, South Korea, or Japan? YES NO
4. Have you or anyone close to you traveled outside the United States in the past 30 days? YES NO
   If yes:
   Names of Countries _____ Dates of Travel _____
5. Have you or anyone close to you traveled to the mountains in Colorado since March 7, 2020? Specifically Eagle, Summit, Pitkin, or Gunnison counties? YES NO