

Dental Partners of Newburyport
COVID-19 Pandemic Period Questionnaire

Patient Name: _____ DOB: _____

Today's Date: _____ Appointment Date: _____

1. Has there been any changes in your medical history since your last appointment? **YES NO**
If yes: _____

2. Have a list of patient's medications ready to review
List all medication changes here:

3. Do you have any of the following:
 - Fever
 - Headache
 - Cough
 - Shortness of Breath
 - Loss of smell or taste

4. Have you been practicing social distancing? **YES NO**

5. Have you been around any individual who has had these symptoms or tested positive for COVID-19? **YES NO**
 - If so, how long has it been since you have had contact with them? _____

6. Have you visited an assisted living, nursing home, hospital, or any place that is treating COVID-19 patients? **YES NO**

7. Have you had the COVID-19 virus? **YES NO**
 - Has a minimum of 72 hours passed since recovery? (resolution of fever without the use of fever reducing medications, and improvement of respiratory symptoms) and at least 7 days passed since your symptoms first occurred? **YES NO -or-**
 - If you had a laboratory confirmed case of COVID-19 but have not had symptoms, has at least 7 days passed since the date of the first positive COVID-19 diagnostic test? **YES NO**

8. Have you had any subsequent illness? **YES NO**
 - Information confirmed on day of appointment
 - Patient's temperature on day of appointment: _____
 - 48-hour patient check