****PATIENT PRE-SCREENING QUESTIONNAIRE****

Due to the ongoing COVID-2019 Pandemic, all caregivers/patients are required to complete this form prior to being seen at Azle Smiles. Effective immediately, only 1 adult is to accompany our patient visits, accompanying children who are not being seen as patients are also restricted. These rules are being enforced to keep our patients and staff as well as the rest of your loved ones safe and healthy.

(Please check yes or no)	YES	NO
Has the patient, caregiver or anyone in your household have travelled outside the US in the past 2 weeks (14 days) IF YES, WHERE _____ ?		
In the past 2 weeks (14 days) has the patient, caregiver or anyone in your household had contact with any person suspected to have contracted coronavirus (COVID-19)? Including being tested for COVID-19, & being in self isolation for COVID-19.		
In the past 2 weeks (14 days) has the patient, caregiver or anyone in your household had contact with any person confirmed to have contracted coronavirus (COVID-19)?		
Has the patient or caregiver currently been exposed to someone with flu-like symptoms (cough, shortness of breath or fever)		
PLEASE CHECK YES or NO (IN THE LAST 72 HOURS HAS THE PATIENT OR CAREGIVER EXPERIENCED)		
FEVER		
COUGHING		
SORE THROAT		
DIFFICULTY BREATHING, SHORTNESS OF BREATH OR WHEEZING		
MUSCLE ACHES		
STOMACH PAINS		
VOMITING OR DIARRHEA		
FATIGUE OR FEELING UNWELL		

Patient/Caregiver:_____ Date:_____

Caregiver temp:_____Patient temp:_____