# COVID-19 PATIENT TRIAGE QUESTIONS

**PATIENT NAME:** _____ **DOB:** _____

**PHONE NUMBER:** _____ **AGE:** _____

| QUESTIONS: | PRE-SCREEN DATE:_____ | | ARRIVAL DATE:_____ | |
|---|---|---|---|---|
| 1. Have you ever been diagnosed with COVID-19? Date of diagnosis:_____ | ☐ YES | ☐ NO | ☐ YES | ☐ NO |
| 2. Do you live with or care for someone who has COVID-19? | ☐ YES | ☐ NO | ☐ YES | ☐ NO |
| 3. Have you had a fever greater than or equal to 100.4° (T≥100.4˚F) in the past 48 hours? | ☐ YES | ☐ NO | ☐ YES | ☐ NO |
| 4. Do you have a sore throat? | ☐ YES | ☐ NO | ☐ YES | ☐ NO |
| 5. Do you have a cough? | ☐ YES | ☐ NO | ☐ YES | ☐ NO |
| 6. Are you experiencing any shortness of breath or difficulty breathing? | ☐ YES | ☐ NO | ☐ YES | ☐ NO |
| 7. Have you recently lost your sense of taste/smell? | ☐ YES | ☐ NO | ☐ YES | ☐ NO |
| 8. Have you experienced vomiting or loose stools recently? | ☐ YES | ☐ NO | ☐ YES | ☐ NO |
| 9. Do you have a headache, body, or muscle aches? | ☐ YES | ☐ NO | ☐ YES | ☐ NO |
| 10. Have you traveled outside of your county in the past 14 days? If yes, where?_____ | ☐ YES | ☐ NO | ☐ YES | ☐ NO |
| 11. Do you have heart, kidney, or lung disease? | ☐ YES | ☐ NO | ☐ YES | ☐ NO |
| 12. Do you have any other condition that might increase your risk of infection such as cancer or diabetes? | ☐ YES | ☐ NO | ☐ YES | ☐ NO |

**This serves as a basic template. Additional questions regarding health issues may be added based on the professional opinion of the dentist.**

**Any positive responses need to be reviewed by the dentist.** If the patient has a temperature, the advice to follow-up with their personal healthcare provider may be the most common response, but temperature alone could be an indication of a dental issue that should be further evaluated.