CHESTERFIELD ORTHODONTICS

COVID-19 SUPPLEMENTAL HEALTH QUESTIONNAIRE

Have you, your child, or others accompanying you to today's appointment or other recent acquaintances **tested positive** for or been diagnosed as having **COVID-19** or any other communicable disease? No_____ Yes_____If yes, when? (date)_____

Do you, your child, or others accompanying you to today's appointment

or other recent acquaintances have:

- A Fever (defined as above 99.6 degrees) Yes/No
- A Cough? Yes/No
- Shortness of Breath and/or Trouble Breathing? Yes/No
- Persistent Pain, Pressure, or Tightness in the Chest? Yes/No
- Other Flu Like Symptoms, such as gastrointestinal upset, headache, or fatigue? Yes/No
- Recent loss of taste or smell? Yes/No
- Over the age of 60? Yes/No
- Any heart disease, kidney disease, diabetes, or Yes/No
- Any autoimmune disorders? Yes/No
- Have you/they traveled in the past 14 days to any regions affected by COVID-19 Yes/No

I understand that if the answer to any of these questions is yes, I may be asked to reschedule today's orthodontic appointment. Positive responses to any of these would likely indicate a deeper discussion with the Orthodontist before proceeding with elective treatment.

Patient's Name:_____

Responsible Party Signature:_____