inspire dental care

COVID-19 Screening Questionnaire

Patient Details

Name: ______________________________ DOB: ______________

Please answer as honestly as possible

Have you tested positive for Covid-19 in the last 7 days? ☐ Yes ☐ No

Are you waiting for a Covid-19 test or test result? ☐ Yes ☐ No

Do you have any of the following symptoms:

- A new continuous cough? ☐ Yes ☐ No
- A high temperature (37.8 °C or over)? ☐ Yes ☐ No
- A loss of, or change in, your normal sense of taste or smell? ☐ Yes ☐ No

Does anyone in your household have or had symptoms suggestive of Covid-19? ☐ Yes ☐ No

If Yes are you still in self/household isolation period? ☐ Yes ☐ No

Are you 'shielding' or considered to be in a vulnerable group for Covid-19? ☐ Yes ☐ No

If yes, please give further details:

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If you are being **accompanied by someone**, do they have any of the above symptoms: ☐ Yes ☐ No

If yes, please give further details:

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Declaration

I declare that the information given above is correct to the best of my knowledge and we will inform the practice immediately if anything changes between now and the next appointment:

Name of the person completing this form: ______________________________

Signed: ______________________________ Date: ______________