MINNEHAHA FALLS
FAMILY DENTAL
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COVID-19 Patient Screening Form

	YES	NO
Have you had a fever or felt hot or feverish in the last 14 days?		
Do you have shortness of breath or other difficulties breathing?		
Do you have a cough?		
Do you have any flu like symptoms or fatigue?		
Have you had any recent loss of taste or smell?		
Have you/Are you in contact with any confirmed COVID-19 positive patients?		
Have you traveled in the past 14 days?		
Are you over 65 years old?		
Do you/Have you had heart disease, kidney disease, lung disease, diabetes, respiratory disease or any auto-immune disorders?		

Positive Responses will likely indicate a deeper discussion with your provider prior to proceeding with urgent or elective care.