L&L DENTAL HYGIENE CLINIC COVID-19 SCREENING QUESTIONNAIRE

*Indicate **Yes** or **No** and provide relevant comments

Patient_____ Date_____

SCREENING QUESTIONS	PRE-APPOINTMENT	IN-OFFICE	48-HOURS POST-APPOINTMENT
Have you had close contact with anyone with acute respiratory illness or travelled outside of Ontario in the last 14 days?			
Do you have a confirmed case of COVID-19 or have you had close contact with a confirmed case of COVID-19?			
DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS: INDICATE YES OR NO			
• Fever			
• New onset of cough			
• Worsening chronic cough			
• Shortness of breath			
• Difficulty breathing			
• Sore throat			
• Difficulty swallowing			
• Decrease or loss of sense of taste or smell			
• Chills			
• Headaches			
• Unexplained fatigue/malaise/muscle aches(myalgias)			
• Nausea/vomiting,diarrhea,abdominal pain			
• Pink eye(conjunctivitis)			
• Runny nose/nasal congestion without other known cause			
If you are 70 years of age or older, are you experiencing any of the following symptoms: • Delirium • Unexplained or increased number of falls • Acute functional decline • Worsening of chronic conditions			

ARE THERE ANY OTHER CHANGES IN MEDICAL HISTORY OR MEDICATIONS (Enter below)			
CONDITION	MEDICATION	DOSAGE	DATE

I have completed a pre-screening prior to my appointment and in-office. I have screened **negative** for COVID-19.
I certify that the above information is complete and accurate on the day of my preventative dental hygiene appointment. I understand L&L Dental Hygiene will follow up 48 hours after my appointment to see if there has been any changes with my health.

Client Signature _____ Date: _____

Parent/Guardian Signature_____ Date: _____
(child screened **negative** for COVID-19)

Lynne Chan, RRDH_____ Date: _____