L&L DENTAL HYGIENE CLINIC COVID-19 SCREENING QUESTIONNAIRE

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

Patient _____ Date _____ Temperature _____ °C

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?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
Do you have a confirmed case of COVID-19 or have you had close contact with a confirmed case of COVID-19?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS: INDICATE YES OR NO			
• Fever	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
• New onset of cough	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
• Worsening chronic cough	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
• Shortness of breath	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
• Difficulty breathing	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
• Sore throat	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
• Difficulty swallowing	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
• Decrease or loss of sense of taste or smell	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
• Chills	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
• Headaches	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
• Unexplained fatigue/malaise/muscle aches(myalgias)	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
• Nausea/vomiting/diarrhea/abdominal pain	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
• Pink eye(conjunctivitis)	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
• Runny nose/nasal congestion without other known cause	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
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	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No

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: _____