DR. BRUCE SEIDBERG -ADVANCED ENDODONTICS - CORONAVIRUS COVID-19 QUESTIONNAIRE

Patient's name _____ Age___ M F Date: April/May ____,2020

Temp _____F Time _____ am pm O_2 ____% **PLEASE CIRCLE YOUR ANSWERS**

Have you been tested for the coronavirus COVID-19? yes no

If yes, did you test positive? yes no

Have you been diagnosed having the coronavirus COVID-19? yes no

Have you been retested & released by the Onon.Co. Health Dept.? yes no

Have you traveled out of the country in the last 3 months? yes no

Have you been in New York City in the last 2 months? yes no

Have you been in any city/state "hot spot" in the last two months? yes no

What city or state? _____

Have you been on a cruise within the last 2 months? yes no

Have you been with anyone who has traveled out of the country or has been in New York City within the last 2 months? yes no

Have you shared living space with anyone who has tested positive? yes no

Have you been with anyone displaying the COVID-19 symptoms within the last 14 days? yes no

Have you been compliant with social distancing? yes no

Have you self-quarantined with in the last month? yes no

If yes, for how long? _____ days

Have you had any of the following symptoms in the last 3 weeks: **(circle answers)**

Dry Cough	yes	no	Fever	yes	no
Sore throat	yes	no	Tiredness	yes	no
Difficulty breathing	yes	no	Loss of taste or smell	yes	no
Unusual aches or pain	yes	no	Unusual GI symptoms	yes	no
Pressure in Chest	yes	no	Red rimmed eyes	yes	no

Patient's or Guardian signature _____