JAMES R. PAYNE, DDS
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COVID-19 QUESTIONNAIRE

Have you had a fever, dry cough, or runny nose in the last 14 days?	Yes	No
Have you experienced shortness of breath or trouble breathing in the last 14 days?	Yes	No
Have you recently had a reduction in your sense of smell or taste?	Yes	No
Have you had a sore throat in the last 14 days?	Yes	No
Have you previously tested positive for COVID-19, or are you currently awaiting test results?	Yes	No
Have you been in close contact with anyone who has tested positive for COVID-19 or with anyone who is currently awaiting test results for COVID-19?	Yes	No
Have you traveled by air, cruise ship, bus, or train in the last 14 days?	Yes	No
Do you live in a nursing home or in a long-term care facility?	Yes	No
Have you been practicing social distancing?	Yes	No
Have you experienced trauma, injury, or uncontrolled bleeding?	Yes	No
Do you have fever and swelling?	Yes	No

Patient Name_____ **Birthdate**_____ **Temperature**_____

Patient/Guardian Signature_____ **Date**_____

Doctor Signature_____ Date_____