Merit Dental®

# COVID-19 Pre-Appointment Questionnaire

**Instructions:** Please complete the questions below prior to your appointment. If you answer YES to any of the questions we may reappoint you for a later date. If you answer NO to all the questions, please print, sign and bring the completed form to your appointment. If you are unable to print the form, you can complete it in our office on the day of your appointment.

| | |
|---|---|
| Have you had contact with anyone confirmed positive for COVID-19 in the last 14 days? | Y \| Ⓝ |

| | |
|---|---|
| Has anyone in your household had close contact with a confirmed or probable COVID-19 case? | Y \| Ⓝ |

| | |
|---|---|
| Have you traveled outside of your state of residence within the last 14 days? | Y \| Ⓝ |
| If yes, please indicate where you traveled and the date of return: | |

| In the past 14 days, have you had symptoms that include: | |
|---|---|
| Fever over 100°F | Y \| Ⓝ |
| Shortness of breath or difficult breathing | Y \| Ⓝ |
| Cough | Y \| Ⓝ |
| Congestion or runny nose | Y \| Ⓝ |
| Headache | Y \| Ⓝ |
| Fatigue | Y \| Ⓝ |
| Gastrointestinal upset | Y \| Ⓝ |
| Nausea or vomiting | Y \| Ⓝ |
| Diarrhea | Y \| Ⓝ |
| Recent loss of taste or smell | Y \| Ⓝ |

| Have you taken any of the following medications in the last 14 day due to a fever: | |
|---|---|
| Acetaminophen | Y \| Ⓝ |
| Ibuprofen | Y \| Ⓝ |
| Naproxen Sodium | Y \| Ⓝ |
| Aspirin | Y \| Ⓝ |

| Full Name (Printed): | Signature: (patient or parent/guardian if a minor) | Date: |
|---|---|---|
| _____ | _____ | _____/_____/_____ |