Dr Johann Lochner Inc

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Patient Name:

	PRE-APPOINTMENT	IN-OFFICE
	Date:	Date:
Do you have fever (Temperature above 38 degrees Celsius, or have you felt hot or feverish recently (14-21 days)? If you have taken your temperature write the value here.	Yes No	Yes No
Are you having shortness of breath or other difficulties breathing?(Tick "yes" if you cannot hold your breath longer than 10 seconds)	Yes No	Yes No
Do you have a cough?	Yes No	Yes No
Do you have flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	Yes No	Yes No
Have you experienced recent loss of taste or smell?	Yes No	Yes No
Are you in contact with any confirmed COVID-19 positive persons? *Patients who are well but who have a sick family member at home with COVID-19 should postpone treatment.*	Yes No	Yes No
Is your age over 65?	Yes No	Yes No
Do you have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders? Please name disease _____	Yes No	Yes No
Have you been vaccinated against the Covid-19 virus? Name of vaccine. _____	Yes No	Yes No

Date of vaccination _____		

Certain responses to any of these would likely indicate a deeper discussion with the dentist before proceeding with elective dental treatment.