



AHMED SHARAF, DDS

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COVID-19 QUESTIONNAIRE

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| 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** _____