Lisa Daft, DMD & Associates, PC

NAME: _____

DATE: _____

TEMP: _____

1. Do you have a cough?	**YES**	**NO**
2. Do you have a fever now or have you in the past 14-21 days?	**YES**	**NO**
3. Have you come in contact with any confirmed COVID-19 positive patients in the last 14 days?	**YES**	**NO**
4. Are you experiencing other flu-like symptoms, such as gastrointestinal upset, headache, fatigue, or difficulty breathing ?	**YES**	**NO**
5. Have you experienced recent loss of taste or smell?	**YES**	**NO**