Lee Dental
AND IMPLANT PRACTICE

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COVID-19 Screening Questionnaire

To prevent the spread of COVID-19 and reduce the potential risk of exposure to our staff and patients, we are conducting a simple screening questionnaire. Your participation is important to help us take precautionary measures to protect you and everyone at our practice. Please do contact us if you are unsure about any of the questions. Thank you for your time.

Patient Details

First Name: **Last Name:** **D.O.B:**

Telephone Number: **E-mail:**

Self-Declaration by above named patient

1.	Have you/have you been in contact with anyone who has been diagnosed with Coronavirus in the past 14 days?	Yes	No
2.	Have you been in contact with anyone who has self-isolated for the past 14 days?	Yes	No
3.	Have you experienced any cold or flu-like symptoms in the past 14 days including the following:	Yes	No
	• A new continuous cough	Yes	No
	• Breathlessness/ More breathless than usual/ Struggle to breathe	Yes	No
	• High Temperature (fever)/Feel hot to touch on chest or back	Yes	No
	• Sore throat/Tacky throat/Soreness when swallowing	Yes	No
	• Loss of taste and or smell	Yes	No
	• Too ill to do daily activities	Yes	No
	• Feeling more confused than normal	Yes	No
4.	Are you aged 70 or over with cardiac/respiratory problem or diabetes?	Yes	No
5.	Have you been advised that you need to be shielded?	Yes	No

Sign: **Date:**

If you have answered Yes to any of the questions, then unfortunately we will be unable to see you for an appointment. If you have answered No to all of the questions, you can proceed to come and see us for your appointment. Please be advised that we will perform a temperature check when you arrive at our practice.