Mary Makhlouf, DMD, MS, PA
Dentistry above and beyond

Patient Name:	Pre-Appointment	In-Office
HOME BP:	Date: HOME Temp	Date: OFFICE Temp
Do you have a **fever** or have you felt hot or feverish recently? (14-21 days)	Yes: No	Yes: No
Are you having shortness of breath, **COUGH** or other difficulties breathing?	Yes: No	Yes: No
Any **Flu**-like symptoms in the last 14-21 days?	Yes: No	Yes: No
Any **other** symptoms, such as gastrointestinal upset, headache or fatigue?	Yes: No	Yes: No
Have you experienced recent temporary loss of **taste or smell**?	Yes: No	Yes: No
Are you **positive** for COVID 19 or have you been in contact with any confirmed COVID-19 positive patients?	Yes: No	Yes: No
Have you had any diarrhea, or **GI** symptoms, **weakness** or falls?	Yes: No	Yes: No
Are you **immune** compromised? Have you had a **transplant**?	Yes: No:	Yes: No:
Do you have heart disease, lung disease, kidney disease, uncontrolled diabetes, or any auto-immune disorder?	Yes: No	Yes: No
Have you **traveled** in the past 14 days by car to a distant location or other form of travel?	Yes: No	Yes: No