Dr. Bunn Family Dentistry | **COVID-19 / WELLNESS FORM**

1. Have you traveled **ANYWHERE OUTSIDE CANADA** in the last 14 days? Yes ____   No ____

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2. Have you been in close contact with family members or close contact with Individuals who have traveled **OUTSIDE OF CANADA** in the last month? Yes ____   No ____

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3. Have you been in close contact with anyone with a suspected or confirmed case of Coronavirus (COVID-19)?

Yes ____   No

____

4. Do you have a pre-existing condition such as lung disease, heart disease, diabetes, kidney disease or an autoimmune disorder? Yes ____   No ____   If yes, please explain which one in detail: ______________________________

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5. Are you experiencing a sore throat? Yes ____   No ____

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6. Do you have a DRY COUGH? Yes ____   No ____

____

7. Do you have a fever (a temperature of 38 degrees celsius or higher) (100.4 degrees Fahrenheit)?

Yes ____   No ____

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8. Have you noticed a recent loss of smell or taste? Yes ____   No ____

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9. Are you experiencing repeated shaking with chills? Yes ____   No ____

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10. Do you have muscle aches or experiencing muscle weakness recently? Yes ____   No ____

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11. Are you experiencing shortness of breath or trouble breathing? Yes ____   No ____

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12. Have you had unexplained headaches lately? Yes ____   No ____

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13. Have you had any of the following: unexplained feeling of fatigue/malaise/nausea /vomiting, diarrhea, or abdominal pain? Yes ____   No ____

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14. Do you have Pink eye (conjunctivitis)? Yes ____   No ____

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15. Have you had a runny nose/nasal congestion without another known cause? Yes ____   No ____

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16. If you are 70 years of age or older; are you experiencing any of the following symptoms: delirium, unexplained or increased number of falls, acute functional decline, or worsening of chronic conditions?

Yes ____ No ____

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17. Have you been hospitalized in the past 6 months? Yes ____ No ____

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18. Have you developed any Drug Allergies or Latex Allergies? Yes ____ No ____

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19. Any changes in your medical history since you were last seen in our office or within the past year?

Yes ____ No ____

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20. Any heart, lung, liver, or kidney disease? Yes ____ No ____

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21. Have you had a joint replacement? Yes ____ No ____

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22. Do you have heart murmur or a heart valve replacement? Yes ____ No ____

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23. Please list your medications including Vitamins and Herbal Supplements, their Dosage and how many times a day you take it.

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OFFICE POLICY: Your appointment time is reserved especially for you. If you are unable to keep the appointment, we require 2 Business Days notice, otherwise it may be necessary to charge for the time lost.

Patient release: I, the undersigned, certify that I have provided accurate and complete information on this form and have not knowingly omitted any pertinent information.

____

Signature Patient ___ Parent ____ Guardian ____ (Please check one)

Please Print Name: ______________________________ Date: ____________________

Reviewing Staff, Personnel: ______________________________ Date: ____________________

Forehead Temperature ________________ B.P. ______________ Pulse (bpm) ________ Oximeter __________