



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 in this building. Thank you for your time.

First Name *

Last Name *

Email Address *

Phone Number *

Have you or have you been in contact with anyone who has been diagnosed with Coronavirus in the last 14 days?

Yes No

Have you been in contact with anyone who has Self Isolated in the last 14 Days?

Yes No

Have you experienced any cold or flu-like symptoms in the last 14 days including a new continuous cough?

Yes No

Have you become breathless, or are you more breathless than usual? Do you struggle to breathe?

Yes No

Do you have a high temperature (fever)? If you don't have a thermometer do you feel hot to touch on your chest or back?

Yes No

A sore throat, a tacky throat or soreness when swallowing food?

Yes No

Have you experienced loss of taste and smell?

Yes No

Are you too ill to do your usual daily activities?

Yes No

Are you feeling more confused than normal?

Yes No

Are you 70 or older with cardiac problems or respiratory problems or diabetes?

Yes No

Have you been advised that you need to be shielded?

Yes No

Your Signature

Today's Date

Please post your completed form to:

Harbour Orthodontic Centre,
17-18 The Waterfront, Sovereign Harbour, Eastbourne, East Sussex, BN23 5UZ