Michael A. Laun DDS,Inc.

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Date * _____

Patient name: *

_____

_____

Current temperature: _____

Do you have a fever or have you felt feverish in the last 14-21 days? * ◯ Yes ◯ No

Are you having any shortness of breath or difficulty breathing? * ◯ Yes ◯ No

Do you have a cough? * ◯ Yes ◯ No

Any other flue like symotoms, such as gastrointestinal upset, headache or fatigue? * ◯ Yes ◯ No

Have you experienced recent loss of taste or smell? * ◯ Yes ◯ No

Have you had contact with a person(s) who confirmed positive for COVID-19? * ◯ Yes ◯ No

Are you age 60 or older? * ◯ Yes ◯ No

Do you have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders? * ◯ Yes ◯ No

If you answered YES, please provide detailed information: *

_____

_____

Have you traveled in the past 14 days to anywhere outside the state of Texas? * ◯ Yes ◯ No

If you answered yes to the travel question, please let us know if it was by car or plane, where to and when you returned.

_____

_____

_____

Response Date: _____