charleston dental associates

Belinda Liles Cordray, D.M.D.

FOR OFFICE USE ONLY

CDA Patient File No.: _____
Date of In-Office Visit: _____
Staff Reviewed Initials: _____

COVID-19 EXPOSURE ASSESSMENT

Patient Name: _____
Date: _____

1. Have you or anyone in your household visited or attended any of the following events, places, or activities:

	You	Household	Initial
Grocery Store	☐ Yes ☐ No	☐ Yes ☐ No	_____
• Name of Grocery Store: _____ _____			
Restaurants	☐ Yes ☐ No	☐ Yes ☐ No	_____
• Name of Restaurants: _____ _____			
Drug Store	☐ Yes ☐ No	☐ Yes ☐ No	_____
• Name of Drug Store: _____ _____			
Bar, Winery, Brewery	☐ Yes ☐ No	☐ Yes ☐ No	_____
• Name of Bar, Winery, Brewery: _____ _____			
Service Station	☐ Yes ☐ No	☐ Yes ☐ No	_____
Gym	☐ Yes ☐ No	☐ Yes ☐ No	_____
Salons (spa)	☐ Yes ☐ No	☐ Yes ☐ No	_____
Indoor Church Service	☐ Yes ☐ No	☐ Yes ☐ No	_____
Indoor Choir Practice	☐ Yes ☐ No	☐ Yes ☐ No	_____

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Temperature of Patient: _____
O2 Level: _____
Pulse: _____

Swimming Pool/Spa	☐ Yes ☐ No	☐ Yes ☐ No	_____
Interstate Rest Stop	☐ Yes ☐ No	☐ Yes ☐ No	_____
Visited Nursing Home	☐ Yes ☐ No	☐ Yes ☐ No	_____
Rehabilitation Facility	☐ Yes ☐ No	☐ Yes ☐ No	_____
Public Park	☐ Yes ☐ No	☐ Yes ☐ No	_____
• Name of Park: _____			
Beach	☐ Yes ☐ No	☐ Yes ☐ No	_____
• Name of Beach: _____			
Weddings, Funerals	☐ Yes ☐ No	☐ Yes ☐ No	_____
Any Family Events	☐ Yes ☐ No	☐ Yes ☐ No	_____
Other Gatherings of More Than 5 People	☐ Yes ☐ No	☐ Yes ☐ No	_____

2. Have you previously been diagnosed with COVID-19, or do you think you've had or currently have COVID-19? ☐ Yes ☐ No

   If the answer is yes, please complete the following:
   ☐ I had a positive nasal swab test on _____(provide date).
   ☐ I currently have symptoms and am awaiting test results.
   ☐ I have not taken a test.

3. If you had COVID-19, how were you confirmed negative?
   ☐ I was confirmed negative by a nasal swab.
   ☐ I show antibodies to COVID-19 with a blood test.

4. If you had COVID-19, when were you confirmed negative?
   ☐ 24 Hours Ago ☐ Today ☐ 10 days after testing ☐ Other: _____

5. Have you or anyone in your household been exposed to COVID-19? ☐ Yes ☐ No

   If the answer is yes, have you or that individual been tested for COVID-19:
   ☐ Yes ☐ No.

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6. Has anyone in your household tested positive for COVID-19?
   ☐ Yes ☐ No If the answer is yes, have they been confirmed negative: ☐ Yes ☐ No

7. Has anyone in your work environment tested positive for COVID-19?
   ☐ Yes ☐ No
   If the answer is yes, have they been confirmed negative?
   ☐ Yes ☐ No

8. Have you traveled by plane, train, bus or boat? ☐ Yes ☐ No
   If the answer is yes, please explain: _____
   _____
   _____

9. Do you, or does anyone in your household, currently have or previously experienced any of the following symptoms in the past twenty-one (21) days?

	You	**Household**	**Initial**
Fever	☐ Yes ☐ No	☐ Yes ☐ No	_____
Altered or Loss of Taste/Smell	☐ Yes ☐ No	☐ Yes ☐ No	_____
Confusion	☐ Yes ☐ No	☐ Yes ☐ No	_____
Bluish Lips or Face	☐ Yes ☐ No	☐ Yes ☐ No	_____
Muscle Pain	☐ Yes ☐ No	☐ Yes ☐ No	_____
Headache	☐ Yes ☐ No	☐ Yes ☐ No	_____
Sore Throat	☐ Yes ☐ No	☐ Yes ☐ No	_____
GI Upset/Diarrhea	☐ Yes ☐ No	☐ Yes ☐ No	_____
Fatigue	☐ Yes ☐ No	☐ Yes ☐ No	_____
Dry Cough	☐ Yes ☐ No	☐ Yes ☐ No	_____
Difficulty Breathing/Shortness of Breath	☐ Yes ☐ No	☐ Yes ☐ No	_____
Chills	☐ Yes ☐ No	☐ Yes ☐ No	_____

I, _____, certify that the foregoing statements made by me are true and accurate.
(Please print patient name)

_____ _____
Patient Signature Date