**AEROSOL TRANSMITTED DISEASE SCREENING FORM**

**NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** D**ATE\_\_\_\_\_\_\_\_\_\_\_\_\_** **Temperature\_\_\_\_\_\_\_\_\_\_\_\_**

**At Sheldon Grove Family Dental, we are committed to make sure you are in an environment that promotes health and well-being in accordance to Cal/OSHA. Any patient experiencing symptoms of air borne diseases such as but not limited to mumps, chickenpox measles, influenza, and tuberculosis must notify us immediately.**

**HYGIENE AND COUGH ETIQUETTE**

**During your time here, we would like to request that you do the following:**

* **Cover your nose and mouth while coughing or sneezing**
* **Use tissues or wipes to when needed**
* **Wash your hands or use sanitizer after you had contact with surfaces potentially contaminated**

Please circle the following:

1. Have you been exposed to anyone with COVID 19? (Y/N)
2. Do you or have you had a fever of 100.4 in the past 2 weeks? (Y/N)
3. Have you had a cough for more than 2 weeks not explained by non-infectious conditions? (Y/N)
4. Have you had coughing episodes that interferes with sleep, eating, &/or breathing? (Y/N)

**Have you experienced in the past month (circle all that apply)**

Stiff neck chills painful /swollen cheeks or jaw Night sweats poor appetite runny nose Unexplained weight loss weakness/malaise watery eyes Muscle ache coughing up blood skin rash or blisters

**Please check the following Aerosol Transmitted Disease (ATD) you have been exposed to IN THE PAST 6 MONTHS**

|  |  |  |
| --- | --- | --- |
| **✓** | **ATDs** | **How long ago** |
|  | COVID-19 (Corona Virus) |  |
|  | Swine Flu |  |
|  | Novel Flu |  |
|  | Scarlett Fever |  |
|  | Avian Flu |  |
|  | Shingles |  |
|  | Chicken Pox |  |
|  | Measles |  |
|  | Monkey Pox |  |
|  | Strep |  |
|  | Severe Acute Respiratory Syndrome (SARS) |  |

|  |  |  |
| --- | --- | --- |
| **✓** | **ATDs** | **How long ago** |
|  | Small Pox |  |
|  | Pneumonia |  |
|  | Parvovirus |  |
|  | Pertussis (whooping cough) |  |
|  | Tuberculosis |  |
|  | Diphtheria |  |
|  | Meningitis |  |
|  | Mumps |  |
|  | Pharyngitis |  |
|  | Epstein Barr |  |
|  | Hemophilus Influenza type “B” or “HIB” |  |

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Patient Signature

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Doctor Signature