Steven C. Wilburn D.M.D.
Kyle B. Wilburn D.D.S

Coronavirus (Covid-19) Questionnaire

Patient name _____ Date_____

Do you have, or have you had within the last 10 days, any of the following:

- Fever Yes or No
- Cough Yes or No
- Shortness of breath Yes or No
- Lethargy Yes or No
- Close contact with a confirmed COVID-19 patient within 14 days of symptom onset Yes or No
- Traveled outside of the continental US in the past 14 days Yes or No
- Have you received the Corona Virus Vaccine Part 1 and Part 2? Yes or No
- Have you received a Booster Vaccine? Yes or No

I certify under penalty of perjury under the laws of California and the United States of America that the foregoing is true and correct.

Signature: _____

****For Office use****

Patient temp today: _____

Notes:

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