PEARLY WHITES

PLEASE COMPLETE THE FOLLOWING

CONTACT INFORMATION:

Name: _____ Date: _____

Address: _____ City: _____ Zip Code: _____ Tel: _____

DID YOU HAVE CONTACT WITH ANYONE WITH ACUTE RESPIRATORY ILLNESS OR TRAVELLED OUTSIDE OF CALIFORNIA IN THE LAST 14 DAYS?

☐ YES ☐ NO

DO YOU HAVE A CONFIRMED CASE OF COVID-19 OR HAVE YOU BEEN IN CLOSE CONTACT WITH A CONFIRMED CASE OF COVID-19?

☐ YES ☐ NO

DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS:

- ☐ Fever
- ☐ New onset of cough
- ☐ Worsening chronic cough
- ☐ Shortness of breath
- ☐ Difficulty breathing
- ☐ Sore throat
- ☐ Difficulty swallowing
- ☐ Decrease or loss of sense of taste or smell
- ☐ Chills
- ☐ Headaches
- ☐ Unexplained fatigue/malaise/muscle ache (myalgias)
- ☐ Nausea/vomiting, diarrhea, abdominal pain
- ☐ Pink eye (conjunctivitis)
- ☐ Runny nose/nasal congestion without other known cause

☐ NO I do not have any of the above symptoms

Signature: _____