

*Questionnaire for Dentist to Tele-screen the patient.¹

NAME: _____ AGE: _____
PATIENT ID: _____ GENDER: _____

| | Yes | No |
|---|--------------------------|--------------------------|
| 1. Do you have a fever or experienced fever within the past 14 days? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you experienced a recent onset of respiratory problems, such as a cough or difficulty in breathing within the past 14 days? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you, within the past 14 days, traveled to a country reported to be infected according to the World Health Organization with documented 2019-nCoV transmission? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you come into contact with a patient with confirmed 2019- nCoV infection within the past 14 days? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you come into contact with people from the neighborhood/region reported to be infected according to the World Health Organization who have recently documented fever or respiratory problems within the past 14 days? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Are there at least two people with documented experience of fever or respiratory problems within the last 14 days having close contact with you? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you recently participated in any gathering, meetings, or had close contact with many unacquainted people? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Urgent Dental Need Question: Do you have uncontrolled dental or oral pain, infection, swelling or bleeding or trauma to your mouth? | <input type="checkbox"/> | <input type="checkbox"/> |

¹ Peng, X., et al., Int J Oral Sci, (2020)