***Dr. Scott Yamaoka***

***Periodontics & Oral Implantology***

 Wellness Form

Please complete form 24 hours prior to appointment time.

|  |  |  |
| --- | --- | --- |
| First Name: |  |  |
| Last Name: |  |  |

**Do you have a cough, shortness of breath, sore throat, loss of smell or taste?**

 **Yes**

 **No**

**In the past few weeks have you had a fever or have you been taking medication to reduce the fever?**

 **Yes**

 **No**

**Have you come in contact with someone experiencing symptoms of COVID-19 in the last 14 days?**

 **Yes**

 **No**

**Have you had COVID – 19?**

 **Yes**

 **No**

**If yes, have you had 2 negative tests since symptoms subsided?**

 **Yes**

 **No**

**Have you travelled internationally or outside the province in the last 14 days?**

 **Yes**

 **No**

 **Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**