Woden Dental Care
Covid 19 Questionnaire Form

Date: _____

Full Name:_____
Address: _____Post code: _____ State: Choose One
Contact Phone Number: _____

1. Have you been overseas within the last fourteen (14) days?
   - ☐ Yes
   - ☐ No
2. If "Yes" on question 2, Where did you go?

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3. If "Yes" on question 2, When did you return from Overseas?
   Date: _____
4. Have you had any following flu-like sickness in the last 14 days?
   - ☐ Cough
   - ☐ Fever or Chills
   - ☐ Headache
   - ☐ Sore throat
   - ☐ Recent loss of smell/taste
   - ☐ Shortness of breath, or other respiratory symptoms
   - ☐ Rhinorrhoea (Running nose)
   - ☐ None of above
5. Have you had any close contact with anyone with a known/suspected Covid 19 case or flu-like symptoms within last 14 days?
   - ☐ Yes
   - ☐ No
6. Have you resided in or visited a known high-risk area with a cluster of cases?
   - ☐ Yes
   - ☐ No

Submit Form