Full Name:_____ Date entire form completed:_____

Email address: _____

Patient Screening for Aerosol Transmissible Diseases (ATD)

IN COMPLIANCE WITH CCR, TITLE 8, SECTION 5199, dental facilities must pre-screen patients for ATD. Dental procedures <u>are not</u> performed on a patient suspected or identified as having ATD. We use this form to pre-screen a patient before any dental procedure is performed to determine whether the patient may present an ATD exposure risk.

<u>Do you have:</u>

A history of Tuberculosis (TB)? Y N If yes, explain: _____

Symptoms of TB?

Productive cough (>3 weeks): Y N If yes, explain: _____

Bloody sputum: Y N If yes, explain: _____

Night sweats: Y N Malaise: Y N Fever: Y N

Fatigue: Y N Unexplained Weight Loss: Y N

Flu & Other Aerosol transmissible diseases, including pertussis, measles, mumps, rubella, chicken pox, meningitis:

Y N If yes, please list: _____

Fever? Y N If yes, how long? _____ Explain: _____

Body aches? Y N If yes, how long? _____ Explain: _____

Runny nose? Y N If yes, how long? _____ Explain: _____

Sore throat? Y N If yes, how long? _____ Explain: _____

Headache? Y N If yes, how long? _____ Explain: _____

Nausea? Y N If yes, how long? _____ Explain: _____

Vomiting and Diarrhea? Y N If yes, how long? _____ Explain: _____

Fever and Respiratory Symptoms? Y N If yes, how long? _____ Explain: _____

Severe Coughing Spasms? Y N If yes, how long? _____ Explain: _____

Painful, swollen glands? Y N If yes, how long? _____ Explain: _____

Skin rash, blisters? Y N If yes, how long? _____ Explain: _____

Stiff neck, mental changes? Y N If yes, how long? _____ Explain: _____

<u>Chronic Respiratory Diseases</u> <u>(NOT ATD's, and not considered infectious)</u>:

<u>Do you have:</u>

Asthma? Y N **Allergies?** Y N **Bronchitis?** Y N

Chronic upper airway cough syndrome "postnasal drip"? Y N **Emphysema?** Y N

Gastroesophageal reflux disease (GERD)? Y N **Chronic obstructive pulmonary disease (COPD)?** Y N

Dry cough from ACE inhibitors? Y N

After reading through the questions, I declare that I have no changes from my last visit.

Initial:_____ Date:_____ Initial:_____ Date:_____

Initial:_____ Date:_____ Initial:_____ Date:_____

Initial:_____ Date:_____ Initial:_____ Date:_____