Patient Screening for Aerosol Transmissible Diseases (ATD)

Office of Dr. Janet Cubol

Patients Name_____

In compliance with CCR, Title 8, Section 5199, dental facilities must pre-screen patients for ATD. Dental procedures are not performed on a patient suspected or identified as having an ATD.

Do you have?

A history of Tuberculosis? Yes ☐ No ☐ If yes,
explain:_____

Symptoms of Tuberculosis?

Productive cough? (> 3 weeks): Yes ☐ No ☐ If yes,
explain:_____

Bloody sputum? Yes ☐ No ☐ If yes,
explain:_____

Night sweats Yes ☐ No ☐ Malaise Yes ☐ No ☐

Fever Yes ☐ No ☐ Fatigue Yes ☐ No ☐

Unexplained weight loss Yes ☐ No ☐

Flu & Other Aerosol transmissible diseases, including Pertussis, Measles, Mumps, Rubella, Chicken pox, Meningitis:

_____

Do you have any of the following symptoms? How long? Explain:

Fever? Yes ☐ No ☐

_____

Body aches? Yes ☐ No ☐

_____

Runny nose? Yes ☐ No ☐

_____

Sore throat? Yes ☐ No ☐

_____

Headache? Yes ☐ No ☐

_____

Nausea? Yes ☐ No ☐

_____

Vomiting or Diarrhea? Yes ☐ No ☐

_____

Fever and/or Respiratory symptoms? Yes ☐ No ☐

_____

Severe Coughing Spasms? Yes ☐ No ☐

Patients Signature_____ Date_____