

Medical History Addendum

This questionnaire has been implemented as a precautionary measure to help us better serve you and keep you and our team safe; is not intended to suggest an immediate threat.

Patient Name: _____ Date of Birth: _____

1. Have you (or your child) or any family member come into contact with a patient with confirmed COVID-19 (Coronavirus) infection within the past 21 days?

YES NO

2. Have you (or your child) had a fever within the past 14 days?

YES NO

3. Have you (or your child) experienced a recent onset of respiratory problems, such as cough or shortness of breath within the past 14 days?

YES NO

4. Have you (or your child) or any family member, within the past 21 days, traveled to a foreign country or region with high confirmed cases of COVID-19?

YES NO