COVID - 19

SUPPLEMENTAL HEALTH QUESTIONNAIRE

If you have been exposed to COVID-19 there is a risk it may be spread in this medical office. Therefore, for your protection and protection of others, prior to each appointment, we will be asking the following questions to reduce the chances of transmission:

Have you, your child, or others accompanying you to today's appointment or other recent acquaintances tested positive for or been diagnosed as having COVID-19 or any other communicable disease? Yes_____ No_____

If yes, when? Date: _____

Are you, your child, or others accompanying you to today's appointment currently awaiting the results of a COVID-19 test? Yes_____ No_____

Do you, your child, or others accompanying you to today's appointment or other recent acquaintances have:

- A fever in the past 14 days (defined as above 99.6 degrees) Yes_____ No_____
- Shortness of breath and/or trouble breathing? Yes_____ No_____
- A cough? Yes_____ No_____
- Any other flu-like symptoms? (i.e. muscle aches) Yes_____ No_____
- Recent loss of taste and/or smell? Yes_____ No_____
- Have you been in contact with any COVID-19 confirmed patients? Yes_____ No_____
- Have you traveled out of state in the past 14 days? Yes_____ No_____
- Persistent pain, pressure, or tightness in the chest? Yes_____ No_____

_____ _____

Patient Name DOB

I certify that the above responses are true and correct:

_____ _____

Patient/Parent Signature Date