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 ◯