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COVID-Questionnaire

Please complete ALL questions below, ***and return within 24 hours of scheduled appointment***:

1. Have you recently participated in any large gatherings (10 or more attendees) or gatherings with people that you did not know?
   Yes _____ No _____

2. Have you or a member of your household returned from international travel within the last 14 days?
   Yes _____ No _____

3. Have you or a member of your household been sick or had a fever within the last 14 days?
   Yes _____ No _____

4. Have you recently traveled to an area with known local spread of COVID-19?
   Yes _____ No _____

5. Have you come into close contact (within 6 feet) with someone who has a laboratory-confirmed COVID-19 diagnosis in the past 14 days?
   Yes _____ No _____

6. Do you have a fever (greater than 100.4 F or 38.0 C) and/or symptoms of lower respiratory illness such as cough, shortness of breath, difficulty breathing or sore throat?
   Yes _____ No _____

7. If yes, please check the following symptoms you are experiencing:
   Date of symptom onset: _____/_____/_____
   ☐ Fever ☐ Chills ☐ Abdominal Pain ☐ Cough ☐ Headache ☐ Diarrhea
   ☐ Shortness of breath ☐ Sore Throat ☐ Vomiting ☐ Muscle aches ☐ Pneumonia
   ☐ Loss of taste ☐ Lose of smell ☐ Acute Respiratory Distress Syndrome (ARDS)

8. If you are experiencing any of these symptoms did you get tested for COVID-19?
   Yes _____ No _____
   If yes, what was the COVID-19 test result?
   Positive _____ Negative _____

_____ _____
Patient / Parent Signature and Written Name of Patient Date