COVID-19 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 anyone in your household tested **+** for COVID-19?

   YES ◯ NO ◯ If **YES**, when?_____

2. Have you or anyone in your household been exposed to COVID-19 within the past 21 days?

   YES ◯ NO ◯

3. Are you or anyone in your household a healthcare provider or emergency responder?

   YES ◯ NO ◯

4. Have you (or anyone in your household) experienced a fever (over 100.4 F) and/or recent onset of respiratory problems (cough or shortness of breath) within the past 21 days?

   YES ◯ NO ◯

_____ _____

Signature Date