Medical History Addendum

This questionnaire has been implemented as a precautionary measure to help us better serve and keep you and our team safe.

Patient Name: _____ Date of Birth: _____

1. Have you 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 had a fever within the past 14 days?

   YES ○ NO ○

3. Have you experienced a recent onset of respiratory problems, such as cough within the past 14 days?

   YES ○ NO ○

4. Have you experienced a recent onset of respiratory problems, such as shortness of breath within the past 14 days?

   YES ○ NO ○

5. Have you 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 ○