
# COVID-19 Questionnaire

Parent Name: _____

Patient Name: _____

| | PRE-APPOINTMENT | IN-OFFICE |
|---|---|---|
| | DATE: | DATE: |
| Do you have fever or have you felt hot or feverish recently (14-21 days)? | PARENT: Yes No<br>PATIENT: Yes No | PARENT: Yes No<br>PATIENT: Yes No |
| Are you having any shortness of breath or other difficulties breathing? | PARENT: Yes No<br>PATIENT: Yes No | PARENT: Yes No<br>PATIENT: Yes No |
| Do you have a cough? | PARENT: Yes No<br>PATIENT: Yes No | PARENT: Yes No<br>PATIENT: Yes No |
| Any other flu-like symptoms, such as gastrointestinal upset, headache, or fatigue? | PARENT: Yes No<br>PATIENT: Yes No | PARENT: Yes No<br>PATIENT: Yes No |
| Have you experienced a recent loss of taste or smell? | PARENT: Yes No<br>PATIENT: Yes No | PARENT: Yes No<br>PATIENT: Yes No |
| Are you in contact with any confirmed COVID-19 positive patients? *People who are well but who have a sick family member at home or nurses, first responders, etc.* | PARENT: Yes No<br>PATIENT: Yes No | PARENT: Yes No<br>PATIENT: Yes No |
| Has anyone in your household experienced a cough, breathing difficulties, loss of taste or smell, fever, or flu-like symptoms in the past 14 days? | PARENT: Yes No<br>PATIENT: Yes No | PARENT: Yes No<br>PATIENT: Yes No |

***Depending on your answers to these questions, you may be required to reschedule your child's appointment.***