<u>Health Questionnaire – Please indicate the following:</u>

Yes ___ No___ Have you had fever (WITHIN 14 Days?)

Yes ___ No___ Do you currently have a cough, or had shortness of breath, (WITHIN 14 DAYS?)

Yes ____ No___Has a doctor previously asked you to self-isolate or self quarantine (WITHIN 14 DAYS?)

Yes ____No_____Have you had any close contact to an individual diagnosed with COVID 19 (WITHIN 14 DAYS?)

PATIENT NAME_____DATE_____

"Parent Name and phone number" to give the update for today's visit:

_____ _____