# Pre-Screening Questionnaire

Patient Name:_____ Patient Date of birth:_____

***The health and safety of our patients, families, and staff is our utmost priority. Therefore, all parents/guardians are required to complete this form prior to being seen in our office. Additionally, only 1 parent is permitted to accompany the child. Any sibling who is not being seen as a patient is also restricted. When completed, please print and bring with you to your child's appointment.***

In the last 2 weeks (14 days) have you or your child been ill with any other following symptoms: fever, cough, shortness of breath, vomiting, diarrhea, sore throat, rash, red eyes, or flu-like symptoms?

YES or NO

In the last 2 weeks (14 days) have you or your child been exposed to anyone who has the above-mentioned symptoms?

YES or NO

In the last 2 weeks (14 days) have you or your child been exposed to anyone who has or may have Coronavirus (COVID-19, SARS-COV2)? Including being tested for COVID 19 & in self isolation due to their symptoms?

YES or NO

In the last 2 weeks (14 days) have you, your child, family members or close contacts traveled out of the area? This includes travel within the United States as well as internationally.

YES or NO *If yes, where* _____

Do you or your child currently have any of the following symptoms? Please circle your choice.

| | | |
|---|---|---|
| *Cough or shortness of breath?* | *YES* | *NO* |
| *Fever?* | *YES* | *NO* |
| *Vomiting or diarrhea?* | *YES* | *NO* |
| *Sore throat?* | *YES* | *NO* |
| *Red eyes/pink eyes?* | *YES* | *NO* |
| *Rash ?* | *YES* | *NO* |
| *Muscle aches or feeling ill?* | *YES* | *NO* |
| *Loss of taste or smell?* | *YES* | *NO* |

***By signing this form, you are certifying that your answers are true.***

Patient/caregiver name:_____ Patient/caregiver signature: _____

Date: _____