**COVID-19 Patient Screening Questionnaire**

**CIRCLE:**

**YES NO** Have you tested or any household/daily contacts tested positive for COVID-19?

**YES NO** Have you or any household/daily contacts been tested COVID-19 and are awaiting results?

**YES NO** Do you or your child have any of the following respiratory symptoms? Fever, Cough, or Shortness of Breath?

**YES NO** Have you or your child recently loss sense of smell or taste?

**YES NO** Even if you don’t currently have any of the above symptoms, have you or your child experienced any of these symptoms in the last 14 days?

**YES NO** Have you or your child been in contact with someone that tested positive for COVID-19 in the last 14 days?

**YES NO** Have you or your child traveled outside the United States by air or cruise ship in the last 14 days?

**YES NO** Have you or your child traveled within the United States by air, bus or train within the last 14 days?

*\*\*\*Contact our office if you experience any of the above symptoms
within 14 days of this appointment today (903-723-6092). \*\*\**

If you answer YES to any of the above questions, it is possible that you may not be scheduled for or be able to attend an in-office appointment.

Pediatric Associates is taking every measure to ensure the safety of employees and patients.
(copies of office protocol is posted around the waiting room is available for handout)

“However, the office is a place of public accommodation and as a result I could be exposed to the virus that causes COVID-19. My Signature acknowledges that I understand and accept that risk.”

**Patient Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Parent/Guardian:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_