Central Texas
Sports Medicine & Orthopaedics, P.A.

COVID-19 (Coronavirus) Pre-Appointment Screening

1. **Do you currently have these symptoms?**
    a. Fever – Yes or No
    b. Cough – Yes or No
    c. Shortness of breath – Yes or No
2. **In the last 14 days, did you travel internationally or to the areas where COVID-19 (Coronavirus) is widespread, including cruise ship travel?** Yes or No
3. **In the last 14 days, did you come in contact with a suspected or laboratory-confirmed COVID-19 (Coronavirus) case?** Yes or No
4. **Are you over the age of 65?** Yes or No
5. **Do you have any of the following medical conditions – Yes or No (select yes, if you have any one of the following listed below)**
    a. Heart Disease
    b. Lung Disease
    c. Kidney Disease
    d. Diabetes
    e. Chemotherapy, HIV, or other immune disorders, such as lupus or rheumatoid arthritis
    f. Long term use of prednisone or other immunosuppressive medications
    g. Organ transplantation or absence of spleen
    h. Pregnancy

If you answered yes to any of these questions, please note that we will not schedule you for an inperson visit at this time. We are happy to set up a telemedicine visit to provide care and guidance to help you until we can see you at the office. As a reminder if this is a medical emergency, we encourage you to call 9-1-1 or go to the nearest ER.

I, _____, hereby attest that the answers to the questions on this
(Print Patients Name)

_____ are accurate and true to the best of my knowledge.
Date

_____ _____
Signature Patient's Date of Birth