

MEDICAL HISTORY ADDENDUM

**All Star Health
Spine & Sport Care**

Patient Name: _____ **Date Of Birth:** _____

1. Have you (or your child) or any family member come into contact with a patient with confirmed COVID-19 (Coronavirus) infection within the past 21 days?

Yes **No**

2. Have you (or your child) had a fever within the past 14 days?

Yes **No**

3. Have you (or your child) experienced a recent onset of respiratory problems, such as cough or shortness of breath within the past 14 days?

Yes **No**

4. Have you (or your child) or any family member, within the past 21 days, traveled to a foreign country or region with high confirmed cases of COVID-19?

Yes **No**

Patient Signature: _____ **Date:** _____