PATIENT PRE-SCREENING QUESTIONNAIRE

Due to the ongoing COVID-2019 Pandemic, all caregivers/patients are required to complete this form prior to being seen at any Kids First Pediatrics of Raeford and Fayetteville locations. Your visit is subject to approval upon completion of this form. Effective immediately, only 1 adult is to accompany our patient visits (except for newborn visits), accompanying children who are not being seen as patients are also restricted. These rules are being enforced to keep our patients and staff as well as the rest of your loved ones safe and healthy.

	YES	NO
Has the patient, caregiver or anyone in your household have travelled **outside the US in the past 2 weeks (14 days)** **IF YES, WHERE _____**		
Has the patient, caregiver or anyone in your household have travelled **outside of North Carolina in the past 2 weeks (14 days)** **IF YES, WHERE _____**		
In the past **2 weeks (14 days)** has the patient, caregiver or anyone in your household had contact with any person **suspected to have contracted coronavirus (COVID-19)**? Including being ***tested*** for COVID-19, & being in ***self isolation*** for COVID-19		
In the past **2 weeks (14 days)** has the patient, caregiver or anyone in your household had contact with any person **confirmed to have contracted coronavirus (COVID-19)**?		
Has the patient or caregiver currently been exposed to someone **with flu-like symptoms (cough, shortness of breath or fever)**		
PLEASE CIRCLE IF SYMPTOMS ARE CURRENTLY BEING EXPERIENCED BY CAREGIVER, PATIENT OR BOTH		
IN THE LAST 72 HOURS HAS THE PATIENT OR CAREGIVER EXPERIENCED		
FEVER		
COUGHING		
SORETHROAT		
DIFFICULTY BREATHING, SHORTNESS OF BREATH OR WHEEZING		
MUSCLE ACHES		
STOMACH PAINS		
VOMITING OR DIARRHEA		
PINK EYE/ RED EYES		
RASH		
FATIGUE OR FEELING UNWELL		

*****Please return this form to the front desk when completed*****

By signing below, you certify that the answers above are true. Failure to answer truthfully or withholding information intentionally will lead to immediate dismissal from our practice and may be subject to applicable laws during this pandemic.

Patient/Caregiver:_____ **Date:_____**

Caregiver temp:_____ **Patient temp:_____**