**Eye Clinic Pre-Appointment-Medical Questionnaire**

1. Do you have fever/have you felt feverish in the last 14-21 days? \_\_\_\_Yes \_\_\_\_No
2. Are you having shortness of breath or difficulty breathing? \_\_\_\_Yes \_\_\_\_No
3. Do you have a dry cough? \_\_\_\_Yes \_\_\_\_No
4. Any other flu-like symptoms such as gastrointestinal issues, headache or fatigue? \_\_\_\_Yes \_\_\_\_No

5. Have you experienced recent loss of taste or smell? \_\_\_\_Yes \_\_\_\_No

6. Are you in contact with any confirmed COVID-19 positive patients? \_\_\_\_Yes \_\_\_\_No

(Patients who are well but who have a sick family member at home with COVID-19 should consider postponing their appointment with the Eye Clinic.)

7. Are you over the age of 60? \_\_\_\_Yes \_\_\_\_No

8. Do you have the following medical conditions:

* Heart disease \_\_\_\_Yes \_\_\_\_No
* Lung Disease \_\_\_\_Yes \_\_\_\_No
* Kidney disease \_\_\_\_Yes \_\_\_\_No
* Diabetes \_\_\_\_Yes \_\_\_\_No
* HIV/Aids \_\_\_\_Yes \_\_\_\_No

9. Have you traveled outside of Maryland by commercial airline, bus or train in the past 14 days? \_\_\_\_Yes \_\_\_\_No

Your response to these questions may lead to a deeper discussion with the Eye Doctor before proceeding with the eye examination.

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Patient Name (Please Print)

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Patient Signature Date

*(This questionnaire is protected under HIPAA guidelines)*