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COVID-19 QUESTIONNAIRE

Dear patients, in the current epidemiological situation, measures need to be taken to minimize the risks of transmission of the infection within the healthcare facility. Due to this, we ask you to fill in the following questionnaire truthfully. Thank you for your cooperation.

Name and surname: _____ Personal ID: _____

1) Purpose of visit / main symptom:

2) Fever: (now or in the last few days)

☐ No ☐ Yes – how much?

3) Cough: (now or in the last few days)

☐ No ☐ Yes

4) Trouble with breathing, shortness of breath: (now or in the last few days)

☐ No ☐ Yes

5) Loss of smell and/or taste: (now or in the last few days)

☐ No ☐ Yes

6) Are you in quarantine?

☐ No ☐ Yes – why?

7) Have you been in contact with someone who was tested positive for COVID-19?

☐ No ☐ Yes – how many days ago?

8) Have you been in contact with someone who is in quarantine?

☐ No ☐ Yes – how many days ago?

Date: _____ Signature: _____

Accepted by: