Adult Coronavirus (COVID-10) Screening Questionnaire

Please customize this form to suit your research requirements.

The form will be read by a machine. Therefore it is important to use blue or black ballpoint pen and write clearly.

Recipient's name

Date of Birth

D D / M M / Y Y Y Y

Age

Ethnicity *(Please cross one)*

◯ White ◯ Mixed ◯ Asian ◯ Black

Blood Type *(Please cross one)*

◯ A ◯ B ◯ AB ◯ O

Patient's Temperature . °C

Have you travelled outside of the Country in the last 14 days? *(Please cross one)*

◯ Yes ◯ No

Have you had contact with anyone that has travelled to an affected area in the last 14 days? *(Please cross one)*

◯ Yes ◯ No

Do you have any allergies? *(Please cross one)*

◯ Yes ◯ No

During the past 12 months have you had swine influenza or other influenza-like illness? *(Please cross one)*

◯ Yes ◯ No

If you had influenza, mark which symptoms you had and how many days they lasted.

Please cross all that apply

	No	Yes	0-2 days	3-5 days	More than 5
1. Headache	☐	☐	☐	☐	☐
2. Stuffy nose / runny nose	☐	☐	☐	☐	☐
3. Sore throat	☐	☐	☐	☐	☐
4. Cough	☐	☐	☐	☐	☐

Please cross all that apply

	No	Yes	0-2 days	3-5 days	More than 5
5. Shortness of breath	☐	☐	☐	☐	☐
6. Chest pain	☐	☐	☐	☐	☐
7. Fever below 39.0	☐	☐	☐	☐	☐
8. Fever of 39.0 or higher	☐	☐	☐	☐	☐
9. Fever (not measured)	☐	☐	☐	☐	☐
10. Convulsions	☐	☐	☐	☐	☐
11. Other convulsions	☐	☐	☐	☐	☐
12. Joint pain	☐	☐	☐	☐	☐
13. Muscle pain	☐	☐	☐	☐	☐
14. Vomiting, diarrhoea	☐	☐	☐	☐	☐
15. Ear infection	☐	☐	☐	☐	☐
16. Pneumonia	☐	☐	☐	☐	☐

Do you have one or more of the following diseases / conditions?

Please cross one in each line

	1. Asthma	2. Diabetes type 1	3. Diabetes type 2	4. Other lung disease	5. Severe overweight	6. Cardiovascular disease	7. Kidney disease	8. Impaired immune system
Yes	◯	◯	◯	◯	◯	◯	◯	◯
No	◯	◯	◯	◯	◯	◯	◯	◯

Have you had a flu vaccination within the last nine months? *(Please cross one)*

◯ Yes ◯ No

If you have visited a foreign country in the past three months, please indicate here

Please describe how you are feeling Today

Office-use only. *Please leave the following fields empty.*

Covid-19 Test *(Please cross one)*

◯ Positive ◯ Negative