

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

<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<i>D</i>	<i>D</i>		<i>M</i>	<i>M</i>		<i>Y</i>	<i>Y</i>	<i>Y</i>	<i>Y</i>

Age

Ethnicity

- White Mixed Asian Black

(Please cross one)

Blood Type

- A B AB O

(Please cross one)

Patient's Temperature °C

Have you travelled outside of the Country in the last 14 days?

- Yes No

(Please cross one)

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?

- Yes No

(Please cross one)

During the past 12 months have you had swine influenza or other influenza-like illness?

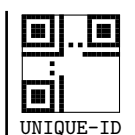
- Yes No

(Please cross one)

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

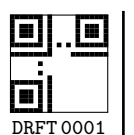
Please cross all that apply

	No	Yes	0-2 days	3-5 days	More than 5
1. Headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Stuffy nose / runny nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Sore throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



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Please cross all that apply

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

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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
No	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Have you had a flu vaccination within the last nine months?

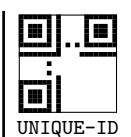
(Please cross one)

Yes

No

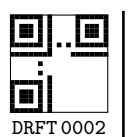
If you have visited a foreign country in the past three months, please indicate here

Please describe how you are feeling Today



To respond or

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

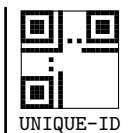
Covid-19 Test

Positive

Negative

(Please cross one)

PREVIEW



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