

Post Coronavirus (COVID-19) recovered patient survey 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.

We offer our software for free to help stop this pandemic as soon as possible. Reach out to support@papersurvey.io to obtain a free licence.

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"/>
D	D		M	M		Y	Y	Y	Y

Age

Ethnicity

☐ White

☐ Mixed

☐ Asian

☐ Black

(Please cross one)

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

☐ Yes

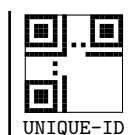
☐ No

(Please cross one)

Mark which symptoms you had and how many days they lasted.

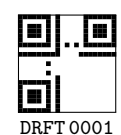
Please cross all that apply

	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"/>
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 type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Vomiting, diarrhoea	<input type="checkbox"/>	<input 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"/>



To respond ☒ or ☐

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Please cross all that apply

16. Pneumonia

No

☐

Yes

☐

0-2 days

☐

3-5 days

☐

More than 5

☐

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

Please cross one in each line

Yes

No

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

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

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

(Please cross one)

☐ Yes

☐ No

How many people you were in contact (in person) with?

After the Coronavirus diagnosis, how many people you were in contact (in person) with?

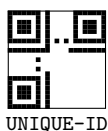
How many days did it take until you have recovered?

Please describe how you are feeling Today

Office Use Only

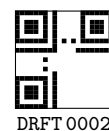
Doctor's Signature

Date discharged

 / / 

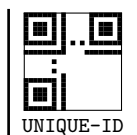
To respond ☒ or ☐

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D D M M Y Y Y Y

PREVIEW



To respond ☐ or ☒

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