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 to obtain a free licence.

Recipient's name

Date of Birth

D D / M M / Y Y Y Y

Age

Ethnicity *(Please cross one)*

◯ White ◯ Mixed ◯ Asian ◯ Black

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

◯ Yes ◯ No

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	☐	☐	☐	☐	☐
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	☐	☐	☐	☐	☐

Please cross all that apply

	No	Yes	0-2 days	3-5 days	More than 5
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

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

☐☐ / ☐☐ / ☐☐☐☐

D D M M Y Y Y Y