Dr Jocelyn Hellig
(0731617)

COVID-19 Questionnaire
2022-01-10 15:27

Patient: **ID/Passport No:** **Completed:** YYYY - MM - DD

Please answer the following questions honestly and in the best interests of staff and patients. Do you have any of the following symptoms? *Understood*

Fever (>38degC) or a history of fever in the past 72 hours?	*Yes*	*No*	
Cough?	*Yes*	*No*	
Sore throat?	*Yes*	*No*	
Difficulty in breathing?	*Yes*	*No*	
Do you have any other flu-like symptoms?	*Yes*	*No*	
Do you have any loss of taste or smell ?	*Yes*	*No*	
In the last 14 days, were you in close contact (<1 m for at least 15 min) with a confirmed COVID-19 case?	*Yes*	*No*	
In the last 14 days, have you been in close contact or living with anybody with flu-like symptoms?	*Yes*	*No*	