HEALTH SCREENING FORM FOR SARS-CoV-2 (COVID19)

univerzitetni klinični center ljubljana

NAME AND SURNAME:

DATE OF BIRTH: **PHONE NUMBER:**

HAVE YOU EXPERIENCED ANY OF THE FOLLOWING COVID-19 SYMPTOMS IN THE PAST 14 DAYS?

fever over 37.5° C	YES	NO
cough	YES	NO
rhinitis	YES	NO
sore throat	YES	NO
vomiting/diarrhea	YES	NO

HAVE YOU TAKEN ANY FEVER-REDUCING MEDICINE BEFORE YOUR VISIT (LEKADOL®, ASPIRIN®, ANALGIN®, BRUFEN®, NAKLOFEN®, NAPROSYN®, KETONAL® …)?

YES NO

If **YES**, specify why. _____

IN THE PAST 14 DAYS, HAVE YOU HAD CLOSE CONTACT WITH A PERSON DISPLAYING ABOVE MENTIONED SYMPTOMS/SIGNS OR WHO HAD A CONFIRMED SARS-CoV-2 INFECTION?

YES NO

ARE YOU VACCINATED AGAINST SARS-CoV-2? YES NO

If **YES**, indicate the NAME OF VACCINE and DATE OF VACCINATION!

Vaccine: _____

First dose (date): _____ Second dose (date): _____ Third dose (date): _____

HAVE YOU RECOVERED FROM SARS-CoV-2 INFECTION? YES NO

If **YES**, specify WHEN. _____

HAVE YOU TRAVELLED ABROAD IN THE PAST 14 DAYS?

If **YES**, specify WHERE TO. _____

**** By signing below, I certify that the answers to the above questions are true.***

Date: _____ Signature: _____

At the University Medical Centre Ljubljana, we strive to ensure the safe treatment of all patients, and your contribution of providing accurate data is greatly appreciated. THANK YOU!

* Under Article 54 of the Communicable Diseases Act, the allegation of false information is a **misdemeanor** and under Article 177 of the Criminal Code, it is a **criminal offense**.