



## QUESTIONNAIRE FOR EPIDEMIOLOGICAL RESEARCH OF CORONAVIRUS (COVID-19)

### GENERAL INFORMATION:

Surname and name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ E-mail: \_\_\_\_\_

### 1. DID YOU EXPERIENCE ANY OF THE LISTED SYMPTOMS IN THE LAST 14 DAYS:

- |                            |     |    |
|----------------------------|-----|----|
| • temperature over 37,5° C | YES | NO |
| • cough                    | YES | NO |
| • nasal congestion         | YES | NO |
| • sore throat              | YES | NO |
| • vomiting/diarrhoea       | YES | NO |

### 2. DID YOU, BEFORE ARRIVING HERE, TAKE ANY MEDICINE THAT LOWERS BODY TEMPERATURE (LEKADOL®, ASPIRIN®, ANALGIN®, BRUFEN®, NAKLOFEN®, NAPROSYN®, KETONAL®...)?

YES NO

If you circled YES, state which medicine you took: \_\_\_\_\_

### 3. HAVE YOU, IN THE LAST 14 DAYS BEFORE THE ONSET OF ILLNESS, BEEN IN CONTACT WITH A PERSON WHO HAD ANY OF THE SYMPTOMS ABOVE?

YES NO

### 4. HAVE YOU, IN THE LAST 14 DAYS, BEEN IN CONTACT WITH A PERSON WHO HAD CONFIRMED INFECTION WITH CORONAVIRUS (COVID-19)?

YES NO

### 5. HAVE YOU BEEN ABROAD IN THE LAST 14 DAYS?

YES NO

### 6. HAVE YOU BEEN PREVIOUSLY DIAGNOSED WITH COVID?

YES NO

I state that the answers to the above questions are true, which I confirm with my signature. I also state, that I am familiar with the notice, which has been attached to this questionnaire.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

