BG Klinikum Duisburg

Health Questionnaire 2020

Name: ____

Date of birth: ______________________________ Date: ____________

Health questionnaire for infection risk assessment / Corona

Have you had a fever / high temperature (above 38°C) in the past 7 days?	○ yes	○ no
Did you have chills?	○ yes	○ no
Do you have a loss of your sense of smell or taste?	○ yes	○ no
Do you have a persistent cough?	○ yes	○ no
Do you have a sore throat?	○ yes	○ no
Do you have a cold (no allergy)?	○ yes	○ no
Do you have diarrhea?	○ yes	○ no
Has your health/wellbeing changed in the last 14 days?	○ yes	○ no
Does a family member or close contact person of yours suffer under any of the above mentioned symptoms?	○ yes	○ no
Have you knowingly been in contact with a person who has been tested Corona virus (COVID 19) positive in the last 14 days?	○ yes	○ no
Have you knowingly been in contact with a person suspected of having the Corona virus (COVID 19) in the last 14 days?	○ yes	○ no
Have you previously been tested positive to Corona/SARS-CoV-2? If so, when? ______________________	○ yes	○ no

_______________ Signature Patient

_______________ HZ Employee