# <QPulse_DocTitle> COVID-19 Patient Screening Questionnaire

This questionnaire should be completed prior to your first clinic visit and as requested by clinic staff.

| **About the patient:** | | | |
|---|---|---|---|
| **First Name** | | **Date of Birth** | |
| **Surname** | | **Patient ID** | |

| **Please answer the following questions by ticking in the box:** | **YES** | **NO** |
|---|---|---|
| 1. Have **you, your partner** or **any member of your household** ever been diagnosed with COVID-19? | | |
| **Within the last two weeks have you, your partner or any member of your household:** | | |
| 2. Had a fever (feeling hot or a temperature above 37.8°C)? | | |
| 3. Had a new persistent cough? | | |
| 4. Experienced loss of the sense of taste or smell? | | |
| 5. Been in contact with anyone who has any of the above symptoms or has been diagnosed with COVID-19? | | |
| 6. Travelled abroad? | | |
| 7. Been advised to self-isolate? | | |
| 8. Taken a COVID-19 test? | | |
| 9. Has your medical history/condition changed since your last visit or since you completed your medical history questionnaire? | | |

**If you have answered yes to any of the above, please give details below:**

**Declaration**

- I confirm that the information I have provided above is accurate.
- I understand that my statements and actions may affect the risk of COVID-19, not just for me, but also for others, including other patients and clinic staff.
- I understand that it is my responsibility that any change in the above should be reported to the clinic in advance of any visit.
- I understand that I will be contacted prior to every clinic attendance to confirm that there is no change in the above information.

| **Signature** | | **Date** | |
|---|---|---|---|