Zdravstveni dom Ljubljana
Community Health Centre Ljubljana

QUESTIONNAIRE FOR THE ASSESSMENT OF MEDICAL CONDITION BEFORE TREATMENT IN THE OUTPATIENT CLINIC DURING THE COVID-19 PANDEMIC

Name and surname of the patient: _____

Date: _____

All questions refer to the CURRENT CONDITION and THE PERIOD OF THE PAST 14 DAYS.

	QUESTION	YES	NO
1.	Do you have a fever (over 37.5 ºC)?		
2.	Do you have a cold?		
3.	Are you coughing?		
4.	Do you have a sore throat or pharynx?		
5.	Do you have a changed sense of taste or smell?		
6.	Do you get a feeling of shortness of breath or tightness in your chest?		
7.	Do you have muscle pain?		
8.	Do you have digestive problems (diarrhoea or vomiting)?		
9.	**Does anyone else at home or at work have such problems?**		
10.	Have you tested positive for COVID-19?		
11.	Have you been in contact with a patient with a confirmed COVID-19 infection (infected relatives, cohabitants)?		

If the answer to any of the questions was YES, consult a GP BEFORE VISITING

By signature, I confirm the truthfulness of all statements.

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