

**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 °C)?		
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...)?		
12.	<b>Have you been abroad in the last 14 days?</b>		
12a.	<b>If your answer is YES, where?</b> _____.		

**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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