

# COVID-19 Patient Questionnaire (Coronavirus SARS-CoV-2)

Name, first name: \_\_\_\_\_ Date of birth:\* \_\_\_\_\_

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

**Have you had any contact (longer than 15 minutes, closer than 2 meters) to a person that suffers from COVID-19?**

- No  
 Yes

**Have you been in a risk-area in the past 14 days?**

- No  
 Yes, I was in \_\_\_\_\_

**Are you sick?**

- No  
 Yes, I suffer from:  sore throat  coughing  high temperature  
 sniffles  breathing difficulties  tastelessness and odorless

**Have you tested yourself on COVID-19 in the past 14 days?**

- No  
 Yes, test result:

**Do one or more of these following risk factors apply to you?**

- \* age over 60 years  
 heart diseases  
 lung diseases (f. ex. asthma, chronic bronchitis)  
 chronic liver disease  
 diabetes  
 oncological patient (chemotherapy)  
 immunosuppressed patient due to illness or therapy

I confirm the correctness of my statements. Should changes occur during the entire treatment period, I will inform the dental surgery immediately.

\_\_\_\_\_  
Place/date

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

\* marked fields are not mandatory