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

Name, first name: _____ Date of birth:* _____

Adress: _____ Phone: _____

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

☐ No
☐ Yes

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: _____ Date of the test : _____
Reason for the test: _____

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.

_____ Signature: _____
Place/date

* marked fields are not mandatory