



## Registration Form for a Patient / Companion Regarding Exposure to the Coronavirus COVID-19

### Personal information / Label

First and last name: \_\_\_\_\_ ID: \_\_\_\_\_

***Please fill in all these details if during the last two weeks you experienced:***

|   |   |   |  |
|---|---|---|--|
| <b>Complaints</b>   | Fever <input type="checkbox"/>  | Shivers <input type="checkbox"/>        | Vomiting <input type="checkbox"/>            |
|   | Cough <input type="checkbox"/>  | Headaches <input type="checkbox"/>      | Diarrhea <input type="checkbox"/>            |
|   | Sore throat <input type="checkbox"/>  | Muscle pain <input type="checkbox"/>    | Loss of smell/taste <input type="checkbox"/> |
|   | Breathlessness <input type="checkbox"/>   | Abdominal pain <input type="checkbox"/> | Other: _____                                 |
| Active disease  | Have you been diagnosed as a coronavirus COVID-19 carrier: Yes / No<br>(if yes – date of the test _____)                  |   |  |
| Stayed abroad during the last month   | Yes / No  |   |  |
| Known exposure to a confirmed or suspected case of COVID-19 or any other infectious disease | Has one of your family members had a fever / runny nose / cough / sore throat or any kind of infection? Yes / No          |   |  |
|   | Has someone you have been in contact with been in quarantine during the last two weeks? Yes / No                          |   |  |
|   | Have you been exposed to a confirmed / suspected corona patient? Yes / No<br>If yes, what was the date of exposure: _____ |   |  |

Sharing the details above will not prevent proper medical treatment.

I hereby declare that all the details noted above are true, and I am aware that concealing information is liable to pose a danger to public health and endanger the medical team.

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Time: \_\_\_\_:\_\_\_\_

Full name: \_\_\_\_\_ Signature: \_\_\_\_\_