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**Self-survey for covid-19 symptoms screening**

Mrs and Mr,

Filling out this survey, **you engage your own responsibility**. Any falsification of the answers can result in significant consequences for your health and the staff that takes care of you. During your care you will be asked to answer this survey several times.

**Thanks to notice the staff as soon as possible of any modification of your situation before your venue at the hospital.**

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| --- | --- | --- |
| Through the last 2 weeks have you: | yes | no |
| - been sick ? |  |  |
| - had fever >38°C ? (please measure your temperature today) |  |  |
| - had any cough ? |  |  |
| -,had sore throat ? |  |  |
| - loosed sense of smell or taste ? |  |  |
| - been in contact with someone or lived with someone who has one of these symptoms? |  |  |
| - have you had any unusual fatigue?  If yes, does it require you to rest more than half of the day? |  |  |
| - have you had stuffy nose? |  |  |
| - have you felt some aches and pains? |  |  |
| - have you had frostbite? |  |  |
| - been in contact with someone or lived with someone diagnosed positive to Covid-19 ? |  |  |
| Within 24 hours, did you notice:  - diarrhea with at least three loose stools?  - unusual shortness of breath when talking or making a small effort? |  |  |
|  |  |
| Have you been diagnosed positive to Covid-19? |  |  |
| Have you been unable to eat or drink for 24 hours or more? |  |  |
| If you have contracted Covid-19 and that you got healed, have you got any medical attestation proving it ? |  |  |
| Have you got any medical history that presents high risks complications in case of Covid-19 ? |  |  |

Name and Surname : Date of birth :

At :  the : Signature :