EPIDEMIOLOGICAL QUESTIONNAIRE FOR MEDICAL PERSONNEL & CLINIC PATIENTS FROM COUNTRIES AFFECTED BY THE COVID-19

1. **Name, surname**:..,

2. **National personal number/DoD ID#**:……...,

3. **Date of birth (DD/MM/YYYY)**:…………………………………………………………………….,

4. **Address (in Poland), phone number**: ....,

5. **Where have you been within last 14 days? (China, India, South Korea, Iran, Italy, others)**.:
…..

6. **Have you (or you family member) been in contact within last 14 days with person having probable or confirmed COVID-19 case (date of last contact, circumstances etc.)**:..
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7. **Do you have or did you have any of the following symptoms?(if yes please indicate the date of onset)**
   1) fever (above 38°C/100,4 F) …………………………………
   2) cough………………………………………………………….
   3) shortness of breath………………………………………….
   4) sore throat…………………………………………………....
   5) loss of smell and taste ……………………………………...

8. **Have you been tested for the presence of coronavirus**

No Yes Date of test :…..................

Result: negative positive

- **antigen test**
- **PCR test**
- **serological test**

9. **Quarantine:**

No Yes Date from……………… to………………….

10. **COVID-19 Vaccination**

No Yes vaccine producer …………………………………

Date of first dose………………….Date of second dose…………………

11. **Other important information**…………………………………………………………………

YOUR SIGNATURE