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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.):..... .....

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