
Covid-19 Symptom Questionnaire

To ensure the safety of everyone involved, please fill in the questionnaire below.

In the event of any Covid-19 infection or suspected infection your details will be shared with the NHS Test and Trace service.

Name

Phone

Do you have or have you had any of the following symptoms in the last 14 days?

Temperature above 37° C Yes No

Persistent cough Yes No

Hoarseness Yes No

Shortness of breathe Yes No

Sore throat Yes No

Wheezing Yes No

Sneezing Yes No

Feeling more tired than usual Yes No

General aches and pains or feeling as if you have the flu Yes No

Loss of sense of taste or smell Yes No

Vomiting or diarrhoea Yes No

Does anyone in your household have or have had any of the above symptoms in the past 14 days? Yes No

Have you or anyone in your household had contact with a confirmed or suspected case of COVID-19 in the past 14 days? Yes No

Signed

Date