Label

HIRSLANDEN
KLINIK STEPHANSHORN

QUESTIONNAIRE COVID-19

please fill out

Last name/first name:
Date of birth: Sex f m
Street: Postal Code/City: Canton:
Mobile phone: Internal telephone, if available:
Email:
Health workers: Yes No if yes: Internal External
Nationality: CH other residence, if not CH:
Occupation: Employer:
Health insurance: general Semi-private Private
Insurance no: Health insurance card no:
AHV number:

please fill out, if understandable and known

Disease state

No symptoms

Start of symptoms:

Symptoms:

- Fever >38° C
- Headaches
- Gastrointestinal symptoms
- Skin rashes
- Cough
- Chest pain
- Loss of smell or taste
- Other symptoms:
- Breathing difficulties
- Sore throat
- Muscle pain

Underlying diseases:

- Diabetes
- Chronic kidney disease
- Chronic respiratory disease
- Smoker
- Cardiovascular disease
- High blood pressure
- Overweight (BMI>35)
- Pregnant
- Immunosuppression
- Cancer
- None
- Other:

In the last 14 days

Where have you been? Switzerland other country: Which one? Place:
If abroad, travel by: Airplane Ship Rail Car/bus Visitors' parking other, which:
Do you live in a home/institution? yes No Which one?
Have you had close contact with a laboratory confirmed case? yes No Unknown
Have you had contact with people who have returned from the UK or South Africa? yes No Unknown
Where might you have caught it?

- Family
- Work
- School/nursery/kindergarten
- Private party
- Club/disco
- Restaurant/bar
- Demonstration/event
- I am a medical or nursing staff
- Other

Date:

Please send the form in advance by e-mail to covid.stephanshorn@hirslanden.ch.

By sending the form I accept the data agreement and agree to the terms and conditions and the data protection declaration.

Remarks:

O2 saturation:

Temperature:

to be filled out by a staff member

Reason for the test:

- Symptoms compatible with COVID-19
- Prescribed by KAD/CONTI
- Notification via App
- preoperative

Asymptomatic patient with test on request: Employer Patient
Responsible doctor:
Release for test: yes No