

Name of Patient: _____

Ward: _____

Name, First Name: _____

Address: _____

Phone Number: _____

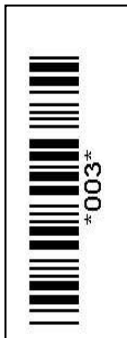
Hospital Admission: Reason: _____

Date: _____

Time: _____

Symptoms	Yes	No	Severity			Start of Symptoms
			slight	moderate	severe	
Sudden onset of illness?	<input type="checkbox"/>	<input type="checkbox"/>				
Acute distress						
At rest?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
At stress?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Fever	<input type="checkbox"/>	<input type="checkbox"/>				max °C
Exhaustion / tiredness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Rheumatic pains	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sore throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Common cold	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Taste disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Smelling disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Others (e.g. swallowing pain, rash)						

did you visit a foreign country in the last 14 days	<input type="checkbox"/> no <input type="checkbox"/> yes, destination?
Have you recently had contact with a person with Corona-infection?	<input type="checkbox"/> no <input type="checkbox"/> yes, location of contact?
Have you recently had contact with a person suspected for a Corona-infection	<input type="checkbox"/> no <input type="checkbox"/> yes, location of contact?
Are you currently located in quarantine ordered by health authorities?	<input type="checkbox"/> no <input type="checkbox"/> yes, until Date: _____
Can you show a current negative Antigene-Quicktest and / or PCR Test	<input type="checkbox"/> no <input type="checkbox"/> yes, date/time of test: _____
Have you already received complete COVID-vaccination?	<input type="checkbox"/> no <input type="checkbox"/> yes, date of last vaccination: _____
Have you suffered from a COVID-infection during the last 6 months?	<input type="checkbox"/> no <input type="checkbox"/> yes, Date: _____
If yes, have you received a single COVID-vaccination after throughgone COVID-infection	<input type="checkbox"/> no <input type="checkbox"/> yes, date of vaccination: _____



Date / Sign Visitor, Patient or Interviewer (has to be filled on day of visit)