KLINIKGUT
ST. MORITZ | FLÄSCH | CHUR | BUCHS | ZÜRICH | ASCONA

Patient questionnaire

Dear patient
We are all doing our best to contain the spread of the coronavirus. To achieve this goal, we ask you to fill out the questionnaire truthfully. We thank you for your valued cooperation. Please let us know immediately should your state of health have changed since you filled out this form.

Last name: ……...…… **First name:** ……………….................

Date of birth: ....

Appointment for: ☐ a consultation ☐ a surgery

Do you have a COVID certificate?

Yes ☐ valid until? ....
→ Please **show the certificate** and answer **only** the questions under **point 1**.
(Zertifikat kontrolliert durch / Visum Mitarbeiter:) ______________________

No ☐ → Please fill in all the **questions** under the **points 1. and 2.**

1. Questions on disease symptoms

In the past 48 hours (2 days), did you show any of the following symptoms?

	Yes	No	If 'yes'	comments
• cough (mostly dry)	☐	☐	.... on date	
• difficulties breathing/ shortness of breath	☐	☐	.... on date	
• fever, feverish feeling, muscle aches	☐	☐	.... on date	
• headache	☐	☐	.... on date	
• sudden loss of the sense of smell and/ or taste	☐	☐	.... on date	

2. Specific questions with regard to COVID-19 (*only to be filled in if no COVID certificate is available)*:

	Yes	No	If 'yes'	comments
• Are you or were you in quarantine or (self-)isolation in the last 14 days?	☐	☐	.... on date	
• Have you had a COVID-19 test in the last 14 days?	☐	☐	.... on date	Result of the test ☐ positive (showing an infection with COVID-19) ☐ negative (absence of a COVID-19 infection)
• Have you been in close contact with a confirmed or suspected COVID-19 person?	☐	☐	.... on date	
• Have you been vaccinated against COVID-19?	☐	☐	1st vaccination on .... 2nd vaccination on	

Place/ date: …………………………………… signature: ……………………………….................
(patient or relative)

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Name: ……..…… **Vorname**: ……………….................

Geburtsdatum: ....

[Dieser Teil wird von der Klinik ausgefüllt.]

Entscheid durch behandelndes Personal:

Wenn Fragen zu den Krankheitssymptomen mit Ja beantwortet
➔ abklären, ob Behandlung unbedingt erforderlich ist

Behandlung durchführen: ☐ Ja (welche Massnahmen sind notwendig?) ☐ Nein

☐ keine speziellen Massnahmen notwendig
☐ Covid-19 Schutzmassnahmen
☐ Behandlung verschieben
☐ andere Massnahmen:

Ort / Datum: …………...............………… Unterschrift: ....
(behandelndes Personal)

[Fragebogen wird eingescannt und in Patientenakte abgelegt]