Corona Checklist for

Surname ______________________________, Name ____________________________

To protect the health and safety of all, we ask for your assistance.
Please go through the checklist conscientiously.
Please only answer the questions which apply to you.

To complete on first consultation -outpatient-	**To complete upon admission for operation -inpatient-**
Have you previously been diagnosed with SarsCov2 ? N☐ Y☐ If yes, when? ________________________ Were you **hospitalized**? N☐ Y☐ If yes, for how long? ________________________	Have you previously been diagnosed with SarsCov2 ? N☐ Y☐ If yes, when? ________________________ Were you **hospitalized**? N☐ Y☐ If yes, for how long? ________________________
When were you vaccinated against SarsCov2 ? 1st vaccination __________________________ 2nd vaccination __________________________ 3rd vaccination __________________________	**When** were you vaccinated against SarsCov2 ? 1st vaccination __________________________ 2nd vaccination __________________________ 3rd vaccination __________________________
Are you planning **a trip abroad in the next 3 months**? N☐ Y☐ If yes, from_________________ until_________________	Have you been **abroad in the past 14 days**? N☐ Y☐
Have you experienced any **new onset** of symptoms (other than known allergic reactions) within the past 14 days? N☐ Y☐ **Please mark with a cross where applicable** o aching limbs o Increased temperature or fever o cough o sore throat o cold o chest pain o shortness of breath o Loss of taste and or smell o Diarrhea Date and signature:_________________________________	Have you experienced any **new onset** of symptoms (other than known allergic reactions) within the past 14 days? N☐ Y☐ **Please mark with a cross where applicable** o aching limbs o Increased temperature or fever o cough o sore throat o cold o chest pain o shortness of breath o Loss of taste and /or smell o Diarrhea Date and signature:_________________________________

The patient has been tested for Covid 19 using the SarsCov2 Rapid Antigen Test

Result: **neg.** ☐ **pos.** ☐ **Test presented** ☐

Date / Signature________________________/______________________________________