TSSF COVID-19 FORM-1
COVID-19 QUESTIONNAIRE

1. Have you ever had COVID-19? Yes **O** No **O**

2. Have you tested positive for COVID-19 by PCR test? Yes **O** No **O**

3. (For those who tested positive) Have you tested negative twice for COVID-19 by PCR test and/or antibody? Yes **O** No **O**

4.Have you had any of the following signs and symptoms during COVID-19 pandemic?

- Shortness of breath or trouble breathing Yes **O** No **O**
- Chest pain Yes **O** No **O**
- Dry cough Yes **O** No **O**
- Fever (38 C or above) Yes **O** No **O**
- Nasal flow, sore throat Yes **O** No **O**
- Loss of taste or smell Yes **O** No **O**
- Diarrhea and stomach ache Yes **O** No **O**
- Severe muscle/joint/head aches Yes **O** No **O**
- Rash Yes **O** No **O**
- Palpitation Yes **O** No **O**
- Tiredness

5. Do you currently have any of the following signs and symptoms?

- Shortness of breath or trouble breathing Yes **O** No **O**
- Chest pain Yes **O** No **O**
- Dry cough Yes **O** No **O**
- Fever (38 C or above) Yes **O** No **O**
- Nasal flow, sore throat Yes **O** No **O**
- Diarrhea and stomach ache Yes **O** No **O**
- Severe muscle/joint/head ache Yes **O** No **O**
- Rash Yes **O** No **O**
- Palpitation Yes **O** No **O**
- Tiredness Yes **O** No **O**

6. Do you currently have any of the following conditions/ illness that may contribute to COVID-19?

- Are you over 50 years of age? Yes **O** No **O**
- Are you overweighed? Yes **O** No **O**
- Do you currently smoke a pipe, cigar or cigarettes? Yes **O** No **O**
- High blood pressure? Yes **O** No **O**
- Asthma/Chronic Obstructive Pulmonary Disease? Yes **O** No **O**
- Coronary heart disease? Yes **O** No **O**
- Diabetes? Yes **O** No **O**
- Cancer? Yes **O** No **O**
- Are you taking medications suppressing immune system? Yes **O** No **O**
- Are there any medications you uses consistently? Yes **O** No **O**
- If yes, please specify.

Name Surname: **Date:** **Signature:**