IVF Athens Center

5 Kifisias ave, 151 23, Maroussi E: info@ivfathenscenter.gr
T: (+30) 210 68 59 500 | 210 68 59 502 T/F: 210 68 59 503

QUESTIONNAIRE COVID

DATE ....

FIRST NAME .... LAST NAME ....

You are kindly requested to answer clearly the following questions.

1. Have you been sick in the last two weeks?

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2. Do you have fever (over 37.5° C)?

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3. Are you coughing at present?

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4. Do you have a sore throat?

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5. Have you lost your sense of smell or taste?

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6. Have you been in contact with somebody who has any of these symptoms?

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7. Have you travelled to an area at high risk for COVID-19, nationally or internationally?

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8. Do you work in a hospital/nursing home or healthcare facility?

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QUESTIONNAIRE COVID

You are kindly requested to answer clearly the following questions.

9. Have you been in contact with somebody who has COVID-19?

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10. Have you been you diagnosed with COVID-19?

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11. Do you live in household with somebody who has been diagnosed with COVID-19 infection or has COVID-19 symptoms (fever, cough, loss of smell)?

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12. If you have been COVID-19 positive and recovered, do you have certified medical evidence of clearance?

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13. Do you have a severe medical condition like diabetes, respiratory disease, chronic kidney disease, etc?