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**QUESTIONNAIRE FOR CHECKING THE PATIENT'S HEALTH STATUS BEFORE TREATMENT
IN THE CLINIC (all questions also refer to the last 14 days):**

Patient's first and last name:

Date:

	QUESTION	YES	NO
1.	Do you have a fever (temperature above 37.5 °C)?	<input type="radio"/>	<input type="radio"/>
2.	Do you have a cold?	<input type="radio"/>	<input type="radio"/>
3.	Do you have a cough?	<input type="radio"/>	<input type="radio"/>
4.	Do you have a sore throat, oesophagus?	<input type="radio"/>	<input type="radio"/>
5.	Are you experiencing changes of taste or smell?	<input type="radio"/>	<input type="radio"/>
6.	Are you experiencing shortness of breath or tightness in your chest?	<input type="radio"/>	<input type="radio"/>
7.	Do you have sore muscles?	<input type="radio"/>	<input type="radio"/>
8.	Do you have digestion problems (diarrhoea or vomiting)?	<input type="radio"/>	<input type="radio"/>
9.	Is anyone at home or work experiencing such problems?	<input type="radio"/>	<input type="radio"/>
10.	Have you tested positive to Covid-19?	<input type="radio"/>	<input type="radio"/>
11.	Have you been in contact with a Covid-19 confirmed patient (sick relatives, roommates)?	<input type="radio"/>	<input type="radio"/>

*** If you answered YES to any of the questions. FIRST CONSULT your primary physician or healthcare provider BY TELEPHONE before treatment.**

By signing, I vouch for the truthfulness of all responses:
