

COVID 19 History Sheet

(to accompany person to hospital)

Full Name:

Date of Birth:

NHS number if known:

Started feeling unwell on:

Temperature: YES ☐ NO ☐

Cough: YES ☐ NO ☐

Difficult breathing: YES ☐ NO ☐

Have you had anything to eat in the past 24 hours? YES ☐ NO ☐

If yes what did you eat and when?

Have you had anything to drink in the past 24 hours? YES ☐ NO ☐

If yes what did you drink and when?

Have you urinated in the past 24 hours? YES ☐ NO ☐

When did you last have your bowels opened?

Have you had any vomiting? YES ☐ NO ☐

If yes which colour was it? Yellow ☐ Green ☐ Blood ☐

Is there anyone else unwell at home or where you live? YES ☐ NO ☐

Have you had any recent foreign travel or known contact with anyone from high risk area or known Coronavirus contact? YES ☐ NO ☐

Have you had any recent treatment different from normal medication for example antibiotic courses? YES ☐ NO ☐

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Your activity level, is this the same as normal? YES ☐ NO ☐

How are you feeling compared to how you normally feel?

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