COVID 19 History Sheet
(to accompany person to hospital)

Full Name: ....

Date of Birth: ....

Medicare Number: ....

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 in the last 14 days or known contact with anyone with COVID-19? 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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