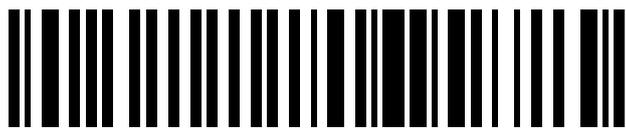


# COVID-19 symptom questionnaire



**30000000170**

Please do not write your name on this questionnaire. We use a barcode to link your responses to your sample.

Please complete this questionnaire on the same day that you provide your blood sample.

Date sample collected: dd/mm/yyyy

Time sample collected: hh:mm

Is this the first sample you have provided?

Yes  No

If this is the first sample you have provided, please tick "Yes" if you have had any of the following since December 2019.

If this is not your first sample, please tick "Yes" if you have had any of the following over the last month (i.e. since you provided your last sample).

	Yes		Yes
Fever 38°C or greater	<input type="checkbox"/> a	Wheezing	<input type="checkbox"/> b
Chills	<input type="checkbox"/> c	Chest pain	<input type="checkbox"/> d
Feeling more tired than usual	<input type="checkbox"/> e	Headache	<input type="checkbox"/> f
Muscle ache	<input type="checkbox"/> g	Nausea/vomiting	<input type="checkbox"/> h
Sore throat	<input type="checkbox"/> i	Abdominal pain	<input type="checkbox"/> j
Persistent dry cough	<input type="checkbox"/> k	Diarrhoea	<input type="checkbox"/> l
Runny nose	<input type="checkbox"/> m	Loss of sense of smell and taste	<input type="checkbox"/> n
Shortness of breath	<input type="checkbox"/> o	Productive long-term cough ('wet' or chesty)	<input type="checkbox"/> p

If you have experienced any of these symptoms, please tick "Yes" if they required you to:

seek medical attention?  Yes self-isolate?  Yes be hospitalised?  Yes

Approximate date when you first experienced any of these symptoms: dd/mm/yyyy

Please use the space below to tell us anything else relevant to this questionnaire:

## Thank you for taking part

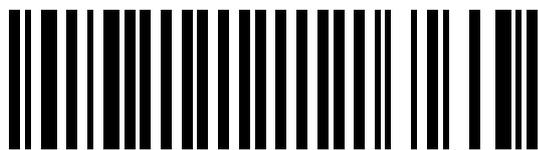
## Spare label if needed

**Date sample collected:**

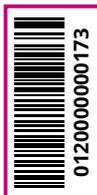
dd/mm/yy

**Time sample collected:**

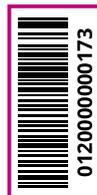
dd/mm/yy



**200000000176**

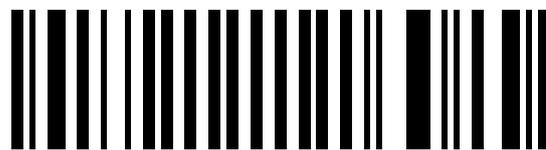


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Please stick this barcode so that the numbers run along the length of your sample tube



**1000000176**