File S1: Questionnaire for risk assessment.

Epidemiological screening COVID-19

Patient/carer details
NAME:
SURNAME:
DATE OF BIRTH:
Personal/Hospital number:

Declaration:

Please declare the following:

1	Within 14 days, have you traveled or residence in the high-risk regions or countries listed by WHO?	YES	NO
2	Within 14 days, have you had contact with those infected with coronavirus (COVID-19 positive)?	YES	NO
3	Within 14 days, have you had direct contact with those with fever or respiratory symptoms?	YES	NO
4	Within 14 days, have you had contact with those who were under quarantine?	YES	NO
5	Have you had symptoms of COVID-19 (fever, cough, short breaths, other flu-like symptoms)?	YES	NO
6	Has anyone from your family members or housemates or work colleagues had symptoms as above?	YES	NO
7	Have you taken paracetamol during the last 12 hours?	YES	NO
8	Have you taken ibuprofen during the last 12 hours?	YES	NO
9	Have you taken aspirin during the last 12 hours?	YES	NO
10	Have you taken any other medications for pain relief? If yes, please list:	YES	NO

In the European context, this questionnaire should be conducted in accordance with the General Data Protection Regulation (GDPR) (EU) 2016/679 and the national data protection regulation.

City……... Date……... Signature……...