

## EPIDEMIOLOGICAL QUESTIONNAIRE

Dear / s,

please complete this questionnaire in accordance with your knowledge and good conscience for the purpose of early detection of respiratory infections caused by SARS CoV-2.

### A. HAVE YOU BEEN TESTED FOR THE SARS-CoV-2 VIRUS?

YES ☐ NO ☐

1. If YES, what type of testing:

- i. ☐ serology (IgA / IgG / IgM Antibody test)
- ii. ☐ rapid antigen test
- iii. ☐ PCR test

2. When: \_\_\_\_\_

3. With what test outcome: \_\_\_\_\_

### B. SYMPTOMS

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| 1. Do you currently have a cold (runny nose, sore throat, etc.)? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 2. Do you cough, or do you have other respiratory problems?      | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 3. Do you stay out of breath?                                    | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 4. Do you have a fever?  | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 5. Do you feel weak or tired?                                    | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 6. Have you noticed reduced or lost sense of taste and smell?    | YES <input type="checkbox"/> | NO <input type="checkbox"/> |

### C. RISK AND CONTACTS

1. Have you traveled outside the borders of the Republic of Croatia for the last 14 days?

YES ☐ NO ☐

i. If YES, where and for how long? \_\_\_\_\_

2. Have you had contact with a person who has been diagnosed with a new coronavirus (SARS-CoV-2) in the last 14 days?

YES ☐ NO ☐

### D. SWAB TEST:

Date: \_\_\_\_/\_\_\_\_/2022. at \_\_\_\_:\_\_\_\_ am/pm

ADDITIONAL FINDINGS IN: ☐ english ☐ german ☐ italian LANGUAGE.

PCR - possible options engl, germ, tal, ANTIGEN - possible option engl



PLEASE FILL IN CAPITAL LETTERS!

NAME AND SURNAME		♀	♂
BIRTH DATE		OIB:	
ADDRESS		PLACE OF RESIDENCE	
PHONE CONTACT		Signature: _____  Location: _____ Date: _____	
EMAIL			
PLEASE COMPLETE IN CAPITAL LETTERS EVEN IF YOUR EMAIL ADDRESS IS WRITTEN IN SMALL LETTERS			

By signing, I agree that my personal data may be used in accordance with the General Data Protection Regulation (GDPR) in accordance with the Information on Data Processing which is an integral part of this questionnaire.

EPID. QUESTIONNAIRE type of document: FORM notice: 20.12.2020. v.1.1. revision: 10.01.2022

Specijalna bolnica za opću kirurgiju, internu medicinu, radiologiju, ginekologiju, neurologiju, psihijatriju, oftalmologiju, fizikalnu medicinu i rehabilitaciju, laboratorijsku dijagnostiku, citologiju, otorinolaringologiju, urologiju, dermatologiju i venerologiju, ortopediju, medicinu rada i anesteziologiju, reanimatologiju i intenzivnu medicinu AGRAM.

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## CONSENT – APPROVAL OF PERSONAL DATA PROCESSING

I hereby state that I have read and understood the text "Information on Data Processing", and that I approve of Special Hospital AGRAM using my personal data for the purposes of its basic activity.

/ I agree that my personal data can be stored in Special Hospital AGRAM's system.

YES ☐

NO ☐

/ I agree that my medical test results can be sent to the following e-mail address \_\_\_\_\_@\_\_\_\_\_

YES ☐

NO ☐

/ I have been acquainted with the right and manner of withholding the given approval at any time.

YES ☐

NO ☐

\_\_\_\_\_  
name and surname, signature

\_\_\_\_\_  
OIB / ID document (number)

If necessary, we will forward your personal data to third persons, but exclusively for the purposes of providing medical services and in the cases foreseen by law. Your data shall be processed confidentially and in accordance with the General Data Protection Regulation, their purpose and the regulations in force.