Adiministrative data:	Date:	ID:

CONFIRMED DIAGNOSIS OF COVID 19: YES [_] NO [_].
(Proceed according)

Investigate symptoms (main symptoms in bold according to CDC)

SYMPTOMS	A | last 3 weeks	B | last 10 days	C | last 3 days
Cough	[_]	[_]	[_]
Shortness of breath or difficulty breathing	[_]	[_]	[_]
Fever	[_]	[_]	[_]
Chills	[_]	[_]	[_]
Repeated shaking with chills	[_]	[_]	[_]
Muscle pain	[_]	[_]	[_]
Headache	[_]	[_]	[_]
Sore throat	[_]	[_]	[_]
New loss of taste or smell	[_]	[_]	[_]
Diarrhea and/or vomiting		[_]	[_]
Pain or pressure in the chest		[_]	[_]
New confusion		[_]	[_]
CONTACTS	**A | last 3 weeks**	**B | last 10 days**	**C | last 3 days**
Close contact with confirmed Covid patient		[_]	[_]

We consider symptomatic:
- Any in C
- 1 main + any other in B
- 2 main or 1 main + 3 other in A