**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 eat 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

Your activity level, is this the same as normal?  Yes / No

How are you feeling compared to how you normally feel?