

Questionnaire - personnel

1. General information:

No.	
Gender	<input type="checkbox"/> Female <input type="checkbox"/> Male
Profession	
Main workplace	<input type="checkbox"/> Eye surgery <input type="checkbox"/> Eye clinic
Previous test for SARS-CoV-2 RNA PCR	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Pos. <input type="checkbox"/> Neg.
Date of previous test	

2. Symptom the last three months

Fever > 38 C	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chills	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fatigue	<input type="checkbox"/> Yes <input type="checkbox"/> No
Muscle aches	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No
Shortness of breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sore throat	<input type="checkbox"/> Yes <input type="checkbox"/> No
Runny nose	<input type="checkbox"/> Yes <input type="checkbox"/> No
Nasal congestion	<input type="checkbox"/> Yes <input type="checkbox"/> No
Difficulty breathing	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sneezing	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chest aches	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other respiratory problem	<input type="checkbox"/> Yes <input type="checkbox"/> No
Headache	<input type="checkbox"/> Yes <input type="checkbox"/> No
Nausea/Vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No
Stomachache	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No
Loss of appetite	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hospital care	<input type="checkbox"/> Yes <input type="checkbox"/> No
Absence from work	<input type="checkbox"/> Yes <input type="checkbox"/> No