# COVID-19 Other Symptoms and Pre-existing Conditions

## 6. Other symptoms Check all that apply

| | | |
|---|---|---|
| □ Sore throat | □ Runny nose | If Yes to any → |
| □ Chest pain | □ Loss of appetite | Start date for first symptom: |
| □ Muscle aches (Myalgias) | □ Neurological signs | _____/_____/_____ |
| □ Fatigue or general malaise | □ Seizures | (DD/MM/YYYY) |
| □ Vomiting or Nausea | □ Rash | |
| □ Diarrhoea | □ Conjunctivitis | |
| □ Headache | □ Other symptoms, specify: _____ | |

## 7. Pre-existing Condition(s) check all that apply

| | |
|---|---|
| ☐ Obesity | ☐ Chronic lung disease (non-asthma) |
| ☐ Underweight | ☐ Chronic liver disease |
| ☐ Hypertension | ☐ Haematological disorder/Sickle cell disease |
| ☐ Diabetes Type 1 | ☐ Chronic kidney disease |
| ☐ Diabetes Type 2 | ☐ Epilepsy |
| ☐ HIV | ☐ Chronic neurological impairment/disease |
| ☐ TB | ☐ Cancer |
| ☐ Heart disease | ☐ Stroke |
| ☐ Asthma (requiring medication) | ☐ Other immune deficiency |
| ☐ Mental health condition: _____ | ☐ Other pre-existing condition: _____ |

| | | |
|---|---|---|
| **7.2 Smoking** | ☐ Current<br>☐ Former<br>☐ Never | |
| **7.3 Vaccinated for influenza last 12 months** | ☐ No<br>☐ Yes →<br>☐ Unknown | Date:_____/_____/_____<br>(DD/MM/YYYY) |
| **7.4 Received pneumococcal vaccine** | ☐ No<br>☐ Yes →<br>☐ Unknown | Date:_____/_____/_____<br>(DD/MM/YYYY) |

## 8. Maternal and Child Health Information

| | | |
|---|---|---|
| **8.1 Pregnant** | ☐ No<br>☐ Yes →<br>→<br>☐ Unknown | Trimester: ☐ First ☐ Second ☐ Third ☐ Unknown<br>Estimated delivery date: _____/_____/_____<br>(DD/MM/YYYY) |
| **8.2 Post-partum**<br>Delivery in last 6 months | ☐ No<br>☐ Yes →<br>☐ Unknown | Delivery date: _____/_____/_____<br>(DD/MM/YYYY) |
| **8.3 Is patient <1 year old?** | YES → **Breastfeeding?** | ☐ Yes<br>☐ No<br>☐ Unknown |
| **8.4 Is patient <5 years old?** | YES → **Are vaccinations up to date?** | ☐ Yes<br>☐ No<br>☐ Unknown |