



### COVID-19 QUESTIONNAIRE

(the data contained herein is subject to medical confidentiality and used for the purpose of qualifying the child's mother for the collection of cord blood)

Name and surname of the mother: .....

Polish Resident ID No. of the child's mother: .....

Contract No. (filled in by the employee): .....

#### FILLED IN BY THE MOTHER:

Choose the answer to your current and best knowledge by placing an "X" next to the answer of your choosing.

1. Have You had infection COVID-19?

YES  NO

2. Over the last 4 weeks, have you experienced any of the symptoms listed below which may indicate that you may have had COVID-19:

	YES (please specify when)	NO	I CAN'T REMEMBER
Fever (temperature over 38 °C)			
difficulty breathing			
dry cough			
muscle or joint pain			
runny nose			
fatigue			

3. During the last 4 weeks have You had a contact with person who had characteristic symptoms for COVID-19?

YES  NO

4. Have you been vaccinated for COVID-19?

YES  NO

If YES, please provide the answers: a) how many times? b) when were You vaccinated (last dose)?

.....

Date .....

Mother's signature .....

Date .....

Signature of the Supervising Physician .....