# Required COVID Questionnaire

**NAME: _____**

**SPORT CLUB: _____**

1) Have you ever been diagnosed with COVID-19 and or its variants?

YES or NO

If you answered yes to question number 1, please answer the following questions:

2) Were you hospitalized for COVID?

YES or NO

If yes, please explain _____

_____

3) With your COVID illness, did you have 4 or more days of fever?

YES or NO

If yes, how many days? _____

4) With your COVID illness, did you have 7 or more days of chills and/or body aches?

YES or NO

If yes, now many days? _____

5) With either the COVID illness OR with return to exercises, did you develop any of the following symptoms?

a. Chest pain? YES or NO

b. Shortness of breath (beyond that expected of deconditioning and/or out of proportion for an upper respiratory tract infection/cold)? YES or NO

If yes, please explain _____

_____

c. New palpitations (heart fluttering/beating too fast/beating too slow)? YES or NO

If yes, please explain_____

_____

d. Fainting? YES or NO