**TABLE FOR HEALTH MONITORING**

During the quarantine, we ask you to regularly and consistently fill in the table for monitoring your health status.

**INSTRUCTIONS FOR COMPLETION**

Consider the following instructions when completing:

* Fill in the table at about the same time each day.
* Enter the observation date and time for each monitoring day.
* Note the symptoms that have occurred or been present in the last 24 hours (in the period since the last observation).
* **Fill in each square in the table.** If you have/feel/perceive this symptom in the last 24 hours, write YES in the box; if you do not have/do not feel/perceive this symptom in the last 24 hours, write NO in the box.
* If YES, you can describe your health status in the same box.
* Measure your body temperature at the same time each day and write it down in the table.
* If you take a medicine to lower your body temperature, write it in the box »Body temperature«.

After the end of the quarantine, please send the completed table for health monitoring to the epidemiological service by email **CNB@nijz.si**or by post:

*Center za nalezljive bolezni (CNB)*

*Nacionalni inštitut za javno zdravje (NIJZ)*

*Zaloška cesta 29, 1000 Ljubljana*

You MUST mark »personal data« on the envelope.

PERSONAL DATA OF THE HEALTH MONITORING TABLE

Name and family name:­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact information:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Indicate the reason for the quarantine:

* High-risk contact with a confirmed COVID-19 case
* Arrival from another country (specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

Did you live in a joint household with a confirmed COVID-19 case during the quarantine?

YES NO

Have you been tested for a SARS-CoV-2 virus infection?

YES, specify the date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mark the result of the swab:

POSITIVE NEGATIVE

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | 1st day | 2nd day | 3rd day | 4th day | 5th day | 6th day | 7th day |
| Date |  |  |  |  |  |  |  |
| Hour of observation |  |  |  |  |  |  |  |
| Symptoms *(consider symptoms in the last 24 hours; enter YES/NO)* |
| Body temperature *(enter a value; indicate if you have taken medicine to lower your body temperature)* |  |  |  |  |  |  |  |
| Chills |  |  |  |  |  |  |  |
| Malaise |  |  |  |  |  |  |  |
| Fatigue |  |  |  |  |  |  |  |
| Headache |  |  |  |  |  |  |  |
| Muscle and joint pain |  |  |  |  |  |  |  |
| Pain elsewhere *(indicate the location of pain)* |  |  |  |  |  |  |  |
| Watery, red eyes  |  |  |  |  |  |  |  |
| Nasal congestion and discharge |  |  |  |  |  |  |  |
| Loss of taste and/or smell |  |  |  |  |  |  |  |
| Sore throat |  |  |  |  |  |  |  |
| Cough (dry or productive) |  |  |  |  |  |  |  |
| Difficulty breathing |  |  |  |  |  |  |  |
| Chest pain |  |  |  |  |  |  |  |
| Nausea |  |  |  |  |  |  |  |
| Vomiting |  |  |  |  |  |  |  |
| Diarrhoea (liquid and defecation several times daily) |  |  |  |  |  |  |  |
| Skin changes |  |  |  |  |  |  |  |
| Other *(indicate)* |  |  |  |  |  |  |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | 8th day | 9th day | 10th day | 11th day | 12th day | 13th day | 14th day |
| Date |  |  |  |  |  |  |  |
| Hour of observation |  |  |  |  |  |  |  |
| Symptoms *(consider symptoms in the last 24 hours; enter YES/NO)* |
| Body temperature *(enter a value; indicate if you have taken medicine to lower your body temperature)* |  |  |  |  |  |  |  |
| Chills |  |  |  |  |  |  |  |
| Malaise |  |  |  |  |  |  |  |
| Fatigue |  |  |  |  |  |  |  |
| Headache |  |  |  |  |  |  |  |
| Muscle and joint pain |  |  |  |  |  |  |  |
| Pain elsewhere *(indicate the location of pain)* |  |  |  |  |  |  |  |
| Watery, red eyes |  |  |  |  |  |  |  |
| Nasal congestion and discharge |  |  |  |  |  |  |  |
| Loss of taste and/or smell |  |  |  |  |  |  |  |
| Sore throat |  |  |  |  |  |  |  |
| Cough (dry or productive) |  |  |  |  |  |  |  |
| Difficulty breathing |  |  |  |  |  |  |  |
| Chest pain |  |  |  |  |  |  |  |
| Nausea |  |  |  |  |  |  |  |
| Vomiting |  |  |  |  |  |  |  |
| Diarrhoea (liquid and defecation several times daily) |  |  |  |  |  |  |  |
| Skin changes |  |  |  |  |  |  |  |
| Other *(indicate)* |  |  |  |  |  |  |  |