

# DIVER POST COVID REVIEW QUESTIONNAIRE

## Triage for returning to diving

**Sticker  
Name  
DOB.**

What date was your positive test? DATE:.....

What type of test was performed? RAT  PCR

What date did you finish isolation? DATE:.....

Have you had a confirmed negative COVID test since completing isolation? YES  NO

What were your COVID symptoms (Tick if yes where appropriate): YES NO

- No symptoms – COVID positive confirmed by testing  YES  NO
- Fever or sweats  YES  NO
- Loss of smell or taste  YES  NO
- Runny Nose  YES  NO
- Sore throat  YES  NO
- Cough  YES  NO
- Shortness of breath  YES  NO
- Chest Pain or palpitations  YES  NO
- Dizziness, disorientation or impaired thinking  YES  NO
- Headache  YES  NO
- Abdominal Pain or Nausea or diarrhoea  YES  NO
- Muscle Aches and Pains  YES  NO

How many days did your symptoms last? (Circle)? 0 1 2 3 4 5 6 7 >7

When did you become free of symptoms? DATE:.....

What is your most intense current exercise undertaken?

How frequently are you exercising?

Did you require hospital-based or GP care at home? YES  NO

Were you admitted to hospital? YES  NO

What treatment did you receive (tick if yes)?

- No Treatment
- Simple pain relief/ fever management (eg paracetamol or ibuprofen)
- Stronger pain relief (Medication Name:.....)
- Antiviral treatment
- Anti nausea medication
- Steroid Medication: Inhaled , oral  or intravenous/IV
- Oxygen support to breathe?
- ICU Admission

Did COVID-19 cause health complications for any of your major organs? YES  NO

Which Organs?

Do you have any ongoing difficulties such as an impaired sense of smell, chest pain, breathlessness with exertion, or issues with your memory? YES  NO