RECIF-MG
RECIF-ALSACE
ETUDE COVIDÉ

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Date :

Country : **Region :**

Physician ID:[(1)(3)] **Patient number :**[(2)(3)]

Annex 2: 'Patient ID' need to be fulfilled at the same time and must be filed and preserved in the physician's office.

Initial Questionnaire[(4)]

Contagion : (tick one or several boxes)

□ prolonged contact …….days ago with a Covid-9 positive tested person

□ Covid-19 probable familial contagion

□ probable work-place contagion

□ the patient belongs to health workers such as hospital physicians, liberal physicians, nurses, nurse assistants, medical secretaries, social workers, stretcher bearers, ambulance driver, student of any of these professions, …) .

□ contagion not known

Patient history: [(5)(5')]

Birthday : …/…/…….(year 4 digits) Postal Code (if any):……...

Patient living in a collective home (retirement residence, with or without medical or nurse assistance): □ Yes □ No

Sex: □ M □ F If pregnancy: …….months of pregnancy

Height: cm Weight: kg

Smoking: □ current □ past ……pack-years □ No

Chronic alcoholism: □ Yes, …… glass/day □ No

Patient seen at the ……..th day after symptoms onset

Non steroidal anti-inflammatory drug taken by the patient –automedication or not- :
□ Yes □ No

Fever: □ Intermittent, fever peak at …… °C, date : ……/……/……
□ Continuous, fever peaks at …… °C □ No

Asthenia: □ Yes □ No Anorexia: □ Yes □ No
Myalgia: □ Yes □ No Throatsore: □ Yes □ No

Rhinitis: □ abondant □ light □ No
Dys/anosmia: □ Yes □ No
Dys/agueusia: □ Yes □ No
Cough: □ dry, since …..… days □ oily, since …….days □ No
Dyspnea: □ Yes □ No If Yes, NYHA scale : □ I □ II □ III □ IV

Ocular prurit: □ Yes □ No
Conjonctivitis: □ Yes □ No
Ocular motion pain: □ Yes □ No
Blurred vision sensation: □ Yes □ No

Nausea: □ Yes □ No Vomiting: □ Yes □ No
Abdominal pain: □ Yes □ No abdominal cramps: □ Yes □ No
Liquid diarrhea: □ Yes □ only one episode □ No
Loose stools: □ oui □ only one episode □ No

Thoracic pain: □ Yes □ No
Thoracic oppression: □ Yes □ No
Otalgia: □ Unilateral □ Bilateral □ No

Cutaneous hyperesthesia: □ Yes □ No Scalp pain: □ Yes □ No
Headache: □ Diffuse □ Frontal □ Occipital □ Other □ No
Dizziness: □ Yes □ No
Rachialgia: □ Cervicalgia □ Dorsalgia □ Lombalgia □ No
Lombo-sciatalgia: □ L3 □ L4 □ L5 □ S1 □ ill-defined □ No
Member weakness: □ Yes □ No

Remarks:

Physical Examination:[6]

□ **patient physically present** □ **Teleconsultation**

Temperature: …… °C with Paracetamol taken less than 6 h before: □ oui □ non
Blood pressure: ……. /……. mmHg Cardiac pulse : …… bpm
Glasgow scale: …….

Respiratory frequency per mn: …… SpO2 at rest: ……. %

Conjonctivitis (light or serious): □ Unilateral □ Bilateral □ No
Cervical lymph nodes: □ Yes □ No

Pain at sinusal pression:
Maxillary sinus □ Unilateral □ Bilateral □ No
Frontal sinus □ Unilateral □ Bilateral □ No
Otitis: □ Unilateral □ Bilateral □ No

Cough: □ dry □ oily □ No
Lung auscultation: □ normal
□ Crepitations □ Ronchi □ Sibilances
□ Diminution of vesicular murmur □ Silent auscultation

Remarks :

Prescribed Treatment(s):

□ Antibiotics: Drug name: ……...
Dosage :……. Duration :…..…days
□ Paracetamol
□ Others:

Non-Steroidal Anti-Inflammatory Drugs or steroids are FORMALLY contraindicated for all infectious presentations

Hospitalisation :

Patient addressed to the Emergency room: □ Yes □ No

Patient Antecedents: (7) □ oui □ non

□ Diabetes type 1 (insulino-dependent) □ Diabetes type 2 (non insulino-dependent)
□ Chronic bronchitis □ Asthma
□ Cystic fibrosis
□ HTA □ Cerebral infarction
□ Coronary disease □ Cardiac surgery : ……...
□ Cardiac Insufficiency NYHA scale : □ I □ II □ III □ IV □ not known
□ Kidney Chronic Insufficiency: DFG clearance…… mL/min/1,73 m^2
□ Cirrhosis : □ grade A □ grade B □ grade C □ not known

□ Cancer □ with metastasis □ Partial Remission □ Complete remission
□ Malignant Hemopathy □ chronic □ acute □ partial ou complete remission
Chemotherapy □ current □ past, last cure in ……. (year)
Radiotherapy □ current □ past, last cure in ……. (year)

□ HIV: □ negative PCR □ positive PCR □ declared AIDS CD4 count:

□ Solid organ graft □ hematopoietic stem cells allograft
□ Biotherapy, drug name and dosage: …….
□ Steroid therapy, drug name and dosage: ……..
□ Innate Immunodepression: ……..……..
□ Auto-immune or systemic disease (lupus, MICI, giant cell arteritis, vasculitides …) : …….……..
Remarks :

Patient usual treatment :(8) □ oui □ non
(you may attach the prescription without rewriting it)

For all remarks or questions, please contact us by mail: questionnairecovide@gmail.com

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