APPENDIX 8.1

CLUB / FEDERATION DOCTOR INITIAL MEDICAL QUESTIONNAIRE

Name:		Date:
COVID-19 PERSONAL HISTORY		
Did you suffer from COVID-19: Confirmed___ / Possible ____	Did you require medical management: Phone ____/ Health Centre ___/ Hospital _____/ ICU _____ / Home __	Where did you receive medical attention? Name of the centre: __________________
Were you admitted to Hospital (hospitalised) as In-patient? Yes__ No __	Who provided your medical attention: Doctor Name: ________________	Do you have a full medical discharge report: Yes____/NO____
Discharge date: _______________________	Confirmed by diagnostic test: Yes___/NO___	**PCR**: Yes____ / No ___ Result: ____ **Date**:
Rapid (point-of-care, prick test) test: Yes____ / No ___ Result: ____ Date:	Serologic Antibody test: Yes____ / No ___ Result: ____ Date:	
Past Symptoms: What symptoms did you have?		
Fever: Yes__/ No __	Cough: Yes__/ No __	Dyspnoea: Yes__/ No __
Running nose: Yes__/ No __	Sore throat: Yes__/ No __	Headache: Yes__/ No __
Fatigue: Yes__/ No __	Dizziness: Yes__/ No __	Muscle Ache: Yes__/ No __
Anosmia: Yes__/ No __	Dysgeusia: Yes__/ No __	Eye itching: Yes__/ No __
Redness of eye: Yes__/ No __	Diarrhoea: Yes__/ No __	Vomiting: Yes__/ No __
Palpitations: Yes__/ No __	Mood swings: Yes__/No __	Distal skin lesions: Yes_/ No __
Chest Pain: Yes__/ No __	Syncope: Yes__/ No __	Other: ______________________________
Received Treatment: ____		
Any further tests (PCR, Blood) **after discharge**; Yes ____ / No _____	PCR: Yes____ / No ___ Result: ____	Rapid (point-of-care, prick test) test: Yes____ / No ___ Result: ____
Serologic Antibody test: Yes____ / No ___ Result: ____	Did you do quarantine **after discharge**? Yes ___/ No___	Quarantine starting date: ______________ Quarantine finishing date: ______________
Personal History of Medical Conditions: ______________________________________		
Epidemiologic history		
Recent contact with:	Known COVID-19 case:	
	Suspected COVID-19 case:	
If recent contact; Did you quarantine? Yes ___/No___	Quarantine starting date: ________	Quarantine finishing date: __________
Vital signs:		
Temperature: ____Degrees	BP: ___/___ mm Hg	HR: ____ bpm
Current Symptoms		
Fever: Yes__/ No __	Cough: Yes__/ No __	Dyspnoea: Yes__/ No __
Running nose: Yes__/ No __	Sore throat: Yes__/ No __	Headache: Yes__/ No __
Fatigue: Yes__/ No __	Dizziness: Yes__/ No __	Muscle Ache: Yes__/ No __
Anosmia: Yes__/ No __	Dysgeusia: Yes__/ No __	Eye itching: Yes__/ No __
Redness of eye: Yes__/ No __	Diarrhoea: Yes__/ No __	Vomiting: Yes__/ No __
Palpitations: Yes__/ No __	Mood swings: Yes__/No __	Distal skin lesions: Yes_/ No __
Chest Pain: Yes__/ No __	Syncope: Yes__/ No __	Other: ______________________________
IF YOU ARE SUFFERING ANY SYMPTOMS DO NOT PRESENT YOURSELF TO ASPETAR FOR SCREENING		
Remarks:		

Adapted from Beas-Jimenez JdD, et al. 2020. Protocolo del Centro Andaluz de Medicina del Deporte, para el cribado de la infección por SARS-CoV-2 en deportistas [22]

APPENDIX 8.2

CLUB / FEDERATION DOCTOR DAYLY MEDICAL QUESTIONNAIRE

<table>
<tr><td colspan="2">Name:</td><td>Date:</td></tr>
<tr><td colspan="3">Epidemiologic history</td></tr>
<tr><td rowspan="2">Recent contact with:</td><td colspan="2">Known COVID-19 case:</td></tr>
<tr><td colspan="2">Suspected COVID-19 case:</td></tr>
<tr><td>If recent contact; Did you quarantine?
Yes ___/No___</td><td>Quarantine starting date: ________</td><td>Quarantine finishing date: __________</td></tr>
<tr><td colspan="3">Vital signs:</td></tr>
<tr><td>Temperature: _____Degrees</td><td>BP: ___/___ mm Hg</td><td>HR: _____ bpm</td></tr>
<tr><td colspan="3">Current Symptoms</td></tr>
<tr><td>Fever: Yes__/ No __</td><td>Cough: Yes__/ No __</td><td>Dyspnoea: Yes__/ No __</td></tr>
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<tr><td>Chest Pain: Yes__/ No __</td><td>Syncope: Yes__/ No __</td><td>Other: ________________________</td></tr>
<tr><td colspan="3">Remarks:</td></tr>
<tr><td colspan="3"></td></tr>
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