Supplementary Material

COVID-19 Survey

This questionnaire must be applied by health personnel, prior to performing procedures on all patients entering the ward.

Name: _____Age: _____

Address:_____Phone: _____

Answer + or -

1	**Have or did you have fever? (Over 37,8°C)**	
2	**Have you had headaches?**	
3	**Have you had respiratory symptoms such as dry cough, sore throat, loss of smell and/or taste, runny nose, or shortness of breath?**	
4	**Have you had any digestive symptoms lately?**	
5	**Have you been in direct contact with someone under suspicion or confirmation of COVID19 infection?**	
6	**Have you traveled abroad or to other areas of the country with confirmed COVID-19 cases in the last 14 days?**	
7	**Are you currently under quarantine? Or have you been indicated to do it previously?**	
8	**Have you taken a test for COVID-19 infection in the last 24–48 h?**	
9	**Have you been diagnosed with COVID-19?**	