SPUMS DIVER POST COVID REVIEW QUESTIONNAIRE DATE:
Triage for returning to diving

Sticker
Name
DOB.

How many COVID vaccinations have you had?...................

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	☐	☐
• Fever, sweats or shivers	☐	☐
• Loss of smell or taste	☐	☐
• Runny Nose or blocked nose	☐	☐
• Sore throat	☐	☐
• Cough	☐	☐
• Shortness of breath	☐	☐
• Chest Pain or palpitations	☐	☐
• Dizziness, disorientation, or impaired thinking	☐	☐
• Headache	☐	☐
• Abdominal Pain or nausea or diarrhoea	☐	☐
• Muscle Aches and Pains	☐	☐
• Fatigue	☐	☐

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 for COVID (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 ☐