Semen Analysis Triaging Questionnaire

Full name……. Date of birth……

1. Have **you** or **your partner** or **any member of your household** been diagnosed with COVID-19?

YES / NO

If Yes, what date was the diagnosis made?.....

2. Have **you** or **your partner** or **any member of your household** had any of the following symptoms in the last 2 weeks **or** returned from South Africa/had any contact with anyone recently returned from South Africa?

- NEW ONSET persistent cough
- Fever (feeling hot or a temperature above 37.8^{o}C)
- Shortness of breath
- Wheezing or sneezing
- Sore throat
- Loss of sense of smell and/or taste
- Nasal discharge or congestion
- Sickness or diarrhoea

YES / NO

3. Have **you** been in contact with anyone who has recently had any of these symptoms or has been diagnosed with COVID-19?

YES / NO

If Yes, how many days has it been since this contact?.....

IF YOU HAVE ANSWERED YES TO ANY OF THE QUESTIONS YOU MAY NEED TO RE-ARRANGE YOUR APPOINTMENT. PLEASE CONTACT LEICESTER FERTILITY CENTRE 0116 258 5922.

Patient Signature…… Date……