Updated – August 2022

CUBIC MRI - COVID-19 Questionnaire:

Name: ____

Date of Birth: ___________________ Scan Date: ___________________

Please read the questions carefully and answer to the best of your knowledge. If anything is unclear, please ask the research staff member.

Do you have:	
a high temperature or shivering	Yes / No
a new, continuous cough	Yes / No
a loss or change to your sense of smell or taste	Yes / No
shortness of breath	Yes / No
feeling tired or exhausted	Yes / No
an aching body	Yes / No
a headache	Yes / No
a sore throat	Yes / No
a blocked or runny nose	Yes / No
loss of appetite	Yes / No
diarrhoea	Yes / No
feeling sick or being sick	Yes / No

If you have any of these symptoms, as per NHS advice, you should try to stay at home and avoid contact with others.

Seek further advice from NHS website if necessary or contact your GP.

Signature:_____________________________ Date:_________________
(for children under 18 years: signature by child and a parent or guardian)

FOR STAFF USE:

Signature: ____________________ **Name: ________________________**