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°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………………………