My COVID-19 symptoms diary

Each day, fill out the table. Write down which of these symptoms you have on Day 1 by writing yes or no, then from Day 2, if your symptom is the SAME (S), BETTER (B) or WORSE (W) than the day before.

Symptom	Day 1 Date:	Day 2 Date:	Day 3 Date:	Day 4 Date:	Day 5 Date:	Day 6 Date:	Day 7 Date:	Day 8 Date:	Day 9 Date:	Day 10 Date:	Day 11 Date:	Day 12 Date:	Day 13 Date:	Day 14 Date:
Fever (Temp and time)														
Loss of smell														
Loss of taste														
Difficulty breathing														
Cough														
Muscle aches and pains														
Headache														
Fatigue														
Nausea or vomiting														
Diarrhoea														
Chills/Rigors														
Dizziness or lightheaded														
Chest pain														
Reduced urine output														

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My COVID-19 symptoms diary

Here's an extra page if you, your health worker or doctor wants you to keep recording your symptoms.
Each day, fill out the table. Write if your symptom is the SAME (S), BETTER (B) or WORSE (W) than the day before.

Symptom	Day 15 Date:	Day 16 Date:	Day 17 Date:	Day 18 Date:	Day 19 Date:	Day 20 Date:	Day 21 Date:	Day 22 Date:	Day 23 Date:	Day 24 Date:	Day 25 Date:	Day 26 Date:	Day 27 Date:	Day 28 Date:
Fever (Temp and time)														
Loss of smell														
Loss of taste														
Difficulty breathing														
Cough														
Muscle aches and pains														
Headache														
Fatigue														
Nausea or vomiting														
Diarrhoea														
Chills/Rigors														
Dizziness or lightheaded														
Chest pain														
Reduced urine output														

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