



My COVID-19 symptoms diary

If your GP or specialist wants you to record your symptoms, mark whether they are mild (m), worsening (w) or severe (s). If you don't have a symptom, leave it blank.

Symptom	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7	Day 8	Day 9
	Date:	Date:	Date:	Date:	Date:	Date:	Date:	Date:	Date:
Fever	Temp: Time:	Temp: Time:	Temp: Time:	Temp: Time:	Temp: Time:	Temp: Time:	Temp: Time:	Temp: Time:	Temp: Time:
Cough									
Shortness of breath									
Fatigue									
Loss of taste/smell									
Diarrhoea									
Headache									
Sore/scratchy throat									
Muscle aches									
Runny nose									
Chills/night sweats									
Vomiting									
Little or no urination									
Shakes or shivers									



Call 000 immediately if you, or the person you are looking after gets any of the following symptoms

Symptom	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7	Day 8	Day 9
Chest pain or discomfort									
Fainting/dizziness									
Unable to care for self									
Skin cold, clammy, mottled									
Difficulty breathing									
Confusion									
Other notes/information									