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 / /	DAY 2 / /	DAY 3 / /	DAY 4 / /	DAY 5 / /	DAY 6 / /	DAY 7 / /	DAY 8 / /	DAY 9 / /	DAY 10 / /	DAY 11 / /	DAY 12 / /	DAY 13 / /	DAY 14 / /
 **FEVER** TEMP AND TIME														
 **LOSS OF SMELL**														
 **LOSS OF TASTE**														
 **BREATHLESSNESS**														
 **COUGH**														
 **MUSCLE ACHES AND PAINS**														
 **HEADACHE**														
 **FATIGUE**														
 **VOMITING**														
 **DIARRHOEA**														
 **APPETITE**														
 **FLUID INTAKE**														
OTHER:														

NOTES:

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QAIHC
Queensland Aboriginal and Islander Health Council

SYMPTOM	DAY 15 / /	DAY 16 / /	DAY 17 / /	DAY 18 / /	DAY 19 / /	DAY 20 / /	DAY 21 / /	DAY 22 / /	DAY 23 / /	DAY 24 / /	DAY 25 / /	DAY 26 / /	DAY 27 / /	DAY 28 / /
 **FEVER** TEMP AND TIME	/ ____ ____	/ ____ ____	/ ____ ____	/ ____ ____	/ ____ ____	/ ____ ____	/ ____ ____	/ ____ ____	/ ____ ____	/ ____ ____	/ ____ ____	/ ____ ____	/ ____ ____	/ ____ ____
 **LOSS OF SMELL**														
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