Medical Questionnaire

Date: 2020年 月 日 (YYYY/MM/DD)

Circle one that applies.

Name: (The patient / Family / Others)

(1) Symptoms appearing "newly" within 14 days
(If you have following symptoms caused by a medical treatment or a chronic disease, you can choose "No.")

- Fever of 37.5 degrees Celsius or above ⇒ No • Yes
  (if measured) Max °C ( / /2020)
- Feeling feverish ⇒ No • Yes (Since when )
- Cough/Phlegm ⇒ No • Yes (Since when )
- Sudden respiratory distress/shortness of breath ⇒ No • Yes (Since when )
- Intense fatigue ⇒ No • Yes (Since when )
- Abnormal taste and/or smells ⇒ No • Yes (Since when )

(2) Within 14 days, did you have any of the following behaviors?
- Having contact with someone tested positive for coronavirus or someone identified as a close contact ⇒ No • Yes

A staff member will take your temperature if necessary.

☆ Today’s body temperature • °C

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