

COVID-19 Questionnaire (英語)

NAME	GENDER <input type="checkbox"/> Male • <input type="checkbox"/> Female
	Age

1. What's the highest body temperature within 24 hours?

℃

2. Question to those who had the temperature over 37.5°C
How long have you had fever?

Days

3. Please circle the symptoms you have now?

- Physical weariness • Breathlessness • Joint pain • Cough
- Sore throat • Runny nose • Taste disorder/smell disturbance
- Diarrhea • Vomiting • Nausea • Stomach ache

4. Have you had a close contact with those who had diagnosed COVID-19 positive within 4 weeks?

YES • NO

5. Have you travelled overseas or major cities like Tokyo / Osaka region?

If so, tell us the name of the place and the dates of your stay.

Place	Length of stay
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6. Please circle if you have chronic disease.

- Hypertension • Diabetes • Respiratory disease including asthma
- Cerebrovascular disease • Heart disease • Cancer

7. For female patients : Are you pregnant?

YES • NO
