

Car Waiting tent

Covid-19 Medical Questionnaire

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フリガナ		Date of birth	/ / () year old
Name	(Male · Female)	Phone	() -
		Mobile phone	- -
Address	〒 -		
Current place of residence	<input type="checkbox"/> Same as above	〒 -	
Profession	<input type="checkbox"/> Health care workers <input type="checkbox"/> Welfare facilities officials <input type="checkbox"/> Police officials <input type="checkbox"/> Firefighters <input type="checkbox"/> School officials <input type="checkbox"/> kindergarten children <input type="checkbox"/> Restaurant officials <input type="checkbox"/> Unemployed		
Workplace / school name		Work location	city
Current body temperature		SPO2	Pulse

1. What are the symptoms?

- Fever (Maximum body temperature °C /) Sore throat
Cough Smell disorder Joint pain I feel the body is heavy Vomiting
Nausea Diarrhea Numbness Breathing difficulty Headache Dysgeusia
Other(s) 【 】

2. When did the symptom start? (/ AM · PM o'clock)

3. Overseas travel history within the past 2 weeks

- No Yes (/ ~ / Destination :)

4. Did you go to a crowded place within two weeks? No Yes

Event · Dinner party · Karaoke · Sports gym · Business trip Other(s) ()

5. Is there anyone around you who has been diagnosed with a Covid-19?

- No Yes (Family Workplace Other(s) [])

6. Are you allergic to food or medication? No Yes (Food · Drug :)

7. Are there any illnesses you are currently treating? No Yes

- Heart failure Diabetes mellitus Dementia Use of anti-cancer drugs
Dyslipidemia Hypertension Use of immunosuppressants Malignant tumor
Cerebrovascular disease Respiratory disease During dialysis treatment
Chronic kidney disease Obesity (Those with a BMI over 30)

8. Do you have any medicine you are currently prescribed?

- No Yes (Prescription drugs at our hospital Other(s) [])

9. Are you currently smoking?

- No Yes () cigarettes/Day (I smoked in the past)

10. If female, answer the questions below. Are you pregnant, or possibly pregnant?

- No Yes

11. About the car Manufacturer () Colour () Number ()

12. Covid-19 vaccination history

- Not inoculated First time (/ /) Second time (/ /)
Vaccine company name ()

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※Those who receive a fever outpatient will be in principle inspected according to the doctor's instructions.