Please fill out this form thoroughly.

Name:( )
Nationality:( )
Sex: Male( ) Female( )
Age:( )
Date of Birth: (year /month /day)
Present Address:

Business Address:

Phone number:

1. What is the problem?

2. Are you allergic to medication?

3. Which diseases undermentioned have you ever had?
Please put a mark on parentheses and fill in.

– Asthma( ), Heart disease( ), Glaucoma( ), Thyroid disease( ),
Diabetes mellitus( ), Prostate gland( ), Gastric or duodenal ulcer( ),
Gall stone( ), Kidney stone( ), Sinusitis( ), Otitis media( ),
The others( )

Surgery: Appendectomy ( ), Caesarean operation( ), Hysterectomy( ),
other surgeries( )

).

4. Do you have any medicines which a doctor has prescribed for you?
– Yes( ), No( )
If 'Yes', please write them down.
( )

5. (To female) Are you pregnant now?
– Yes( ), No( )

Questionnaire Form

Name : ( )

Gender : Male( ), Female( ).

Date of Birth :(day /month/year) / /

① my temperature today: ( )

② Did you go abroad within 2 weeks? : Yes( ), No( )

How about your roommate? Yes( ), No( )

③ Have you met anyone with close contact or suspicion of COVID -19?

Yes ( ), No ( )

④ Do you have cold symptoms? Yes( ), No( )

⑤ Do you have severe lack of energy or difficulty breathing? Yes ( ), No ( )

⑥ Did you suddenly get a fever within two weeks? Yes ( ), No ( )

⑦ Have you taken antipyretics or analgesics within two weeks? Yes ( ), No ( )

⑧ Do you have a taste or smell problem? Yes ( ), No ( )

⑨ Have you been diagnosed as positive for COVID -19 infection?

Yes ( ), No ( )

Today's date:(/2022