

受付確認表(English)

ID

Arrival date / /

Body temperature

Name of patient		Birth date
	Male / Female	/ /

We kindly ask everyone who enters this hospital to answer the questions below. **Please also answer about your family member who live in the same house.**

■Check below if any applies within two weeks from today.

If any applies for your family member, check the () mark.

- | | |
|---|--|
| ☐ () Fever | ☐ () Taste disorder |
| ☐ () Sore throat | ☐ () Smell disorder |
| ☐ () Cough · Sputum | ☐ () Stomachache with diarrhea |
| ☐ () Fatigue (sense of tiredness) | ☐ () Headache |
| ☐ () Breathing trouble | |

■Check below if nothing applies.

- ☐ I do NOT have/had any of the symptoms listed above within two weeks.

■Have you been abroad within three months?

- ☐ NO ☐ YES

Duration of visit :

Name of country :

WHO? : Yourself · Others ()

■Have you or anyone in your family had a PCR test within two weeks?

- ☐ NO ☐ YES ☐ Planning to get tested because you/family member is a close contact.

The person who was tested :

Date of the PCR test : / /

Result : Negative / Positive / Don't know yet

(Determined date: / /)

(Planned determination date: / /)

The person who was tested :

Date of the PCR test : / /

Result : Negative / Positive / Don't know yet

(Determined date: / /)

(Planned determination date: / /)

■Has anyone at your/family member's workplace/school tested positive to COVID-19 within two weeks?

- ☐ NO ☐ YES