Preliminary examination slip(COVID-19・influenza・fever・diarrhea,nausea)

ID（Fill in at our clinic) **Date**(yyyy /mm/ dd) / / /

For Kimura Family Clinc

Consent form

Name M・F Date of Birth (yyyy //mm/ dd) / / / age years old

〒

address

Emergency Contact

（Name ：relationship ）

Phone☏① — —

phone☏② — —

※Please write two phone numbers

※For minors,please write the name and phone number of a guardian, Adults should write their own phone numberon ①

① Since when have you been unwell?

☐today ☐yesterday・ ☐(yyyy //mm/ dd) / / /

② What are the first symptoms?

☐fever （ ℃） ☐cough ☐phlegm ☐sore throat ☐headache ☐nausea ☐diarrhea ☐snot

③Current symptoms

☐fever ☐cough ☐phlegm ☐sore throat ☐headache ☐nausea ☐diarrhea ☐snot

（fever Max ℃）・（mm/ dd) / /

Body temperature measured in our clinic now （ ℃）

④Has anyone had the COCID-19 or influenza recently?

☐No ☐Yes 【☐family ☐friend ☐school ☐workplace ☐otther： 】

☐COVID-19 ☐influenza（mm/ dd) / /)

⑤Have you recently been infected with COVID-19 or influenza?

☐No ☐Yes (yyyy //mm/ dd) / / /

⑥Have you been to a crowded place in the last 10 day?

☐No ☐Yes (yyyy //mm/ dd) / / / ( )

⑦Do you have any medicine to make you sick or allergy?

☐No ☐Yes→ drug name （ ）

⑧Do you have any illnesses that you are currently undergoing treatment or been hospitalized past?

No・Disease (Kidney・Hert・Lung・Cerebrovascular) ,Diabetes・High blood pressure, Hyper (cholesterol・triglycerides)

Oters （ ） smoking （ ＋・－ ）

⑨Regular Treatment Drug ☐No ☐Yes（drugname： ）

Medical institution name：

⑩History of COVID-19 Vaccination 【 ＋・－ 】

Last Vaccination (yyyy //mm/ dd) / / / times

⑪Please check if women are pregnant or breastfeeding ☐Pregnant ☐Breastfeeding

⑫Can you leave the treatment to us like other patients? ☐Yes ☐No

※This field will be filled out by staff. BT ℃, Wt kg