Mobile No. (- -) Car No. _____ Car Type/Color _____

Name _____ Temperature _____℃

ID _____

Fever Outpatients Medical Questionnaire

1. Have you had a fever of over 37.5℃ since yesterday until now? [YES / NO]
2. When did you first start showing symptoms? [Date: Time:]
3. Have you been infected by Covid until now? [YES / NO]

   If YES, please mention when _____
4. Have you been vaccinated against Covid? [YES / NO]

   If YES, please mention when was your last vaccination

   Date: _____ Dosage No. _____
5. Have you been overseas any time during the last 2 weeks? [YES / NO]

   If YES, Do you have any skin rash or bumps? [YES / NO]
6. Are you living with anyone who has been infected by Covid or the flu? [YES / NO]
7. Did you show a positive result to a Covid or Flu antigen test at home prior to coming to the hospital? [YES / NO]

   If YES, was it [Flu positive / Covid positive]

8. Would you like to take an antigen (Covid + Influenza) test OR a Covid PCR test?

   [YES / NO]

9. What is your profession? [ ]

10. Please ○ your current symptoms?

    ・High fever of above 37.5℃ in the last 24 hours ・Cough ・Phlegm

    ・Breathing Difficulty ・Throat pain ・Lethargy ・Headache ・Nausea

    ・Diarrhea ・Red Eyes ・Lack of Smell/Taste Sense ・Joint pain

    ・Muscle pain ・Loss of Appetite

11. If you have any of the following prevalent conditions, please ○ them

    ・Cancer ・Chronic Respiratory Disease ・Chronic Kidney Disease

    ・Cardiovascular Disease ・Cerebrovascular Disease ・Smoking history

    ・High-blood Pressure ・Diabetes ・Dyslipidemia ・Obesity

    ・Pregnant ・Organ Transplant ・Under Anticancer drug use

    ・Low Immunity due to the use of Immunosuppressant drugs