MEDICAL QUESTIONNAIRE

Please fill in this form before visitation

Month : Day : Outpatient / Hosp. ward :

YOUR NAME : Relationship : Father / Mother /( )

PATIENT NAME :

Body Temp. : _____ . _____ ℃

Do you have any symptoms as follows?

1. Sense of fatigue NO YES

2. Cough NO YES

＊If you have ″YES″ and have hay fever etc., please describe details.

( )

3. Diarrhea, Nausea NO YES

4. Red eye, Eye discharge, Eye discomfort, Teary eyed NO YES

＊If you have ″YES″ and have hay fever etc., please describe details.

( )

5. Exanthema, Painful rush NO YES

＊If you have ″YES″ and have atopic dermatitis etc., please describe details.

( )

6. Contact with novel coronavirus patients or living togather NO YES

7. Overseas travel history within 4 weeks NO YES

8. Epidemic infective disases in the neighborhood NO YES

(Influenza, Enterogastritis, Chickenpox, Measles, Rubella, Mumpus, etc...

Admission Time : Admission Badge No.

Thank you for your cooperatin

KANAGAWA Children's Medical Center