

Name: \_\_\_\_\_ Body Temperature: \_\_\_\_\_ °C

**\* Please inform receptionist if you are having high fever or suspected any infectious disease \*****Please answer the questions below**

- 1 What symptoms do you have?  
 Fever    Cough    Sore throat    Running nose    Shortness of breath    Headache  
 Dizziness    Abdominal pain    Diarrhea    Nausea / vomiting    Rash  
 Palpitation    Chest pain / discomfort    Swelling    Others { \_\_\_\_\_ }
- 2 When did the symptoms start? { \_\_\_\_\_ }
- 3 Have you seen any physician or taken medications for the symptoms above?    Yes    No  
Treatments and / or medications { \_\_\_\_\_ }
- 4 Are you allergic to any foods or medications?    Yes    No  
Foods / medications { \_\_\_\_\_ }
- 5 Have you traveled to any countries within a month?    Yes    No  
Country(ies) { \_\_\_\_\_ }

**For adults only**

- 6 Are you currently undergoing treatments for any diseases or previously had any diseases listed below?  
 High blood pressure    Hyperlipidemia    Diabetes    Gout / Hyperuricemia    Heart disease  
 Asthma    Gastric disease    Liver disease    Others { \_\_\_\_\_ }
- 7 Are you currently under any medications?    No    Yes Medications { \_\_\_\_\_ }
- 8 Do you drink alcohol?    No    I quitted \_\_\_\_\_ years ago    Yes ( \_\_\_\_\_ ML / time, \_\_\_\_\_ times / week )
- 9 Do you smoke?    No    I quitted \_\_\_\_\_ years ago    Yes ( \_\_\_\_\_ cigarettes / day, since \_\_\_\_\_ years ago )

**For ladies only**

- 10 Are you pregnant / possibly pregnant?    Yes    No
- 11 Are you breastfeeding?    Yes    No

**For children only**

Height \_\_\_\_\_ cm   Weight \_\_\_\_\_ kg

- 12 How was he / she when he / she was born?    Normal    Abnormal { \_\_\_\_\_ }
- 13 Have he / she ever been suspected to have any abnormality in development?  
 No    Yes { \_\_\_\_\_ }
- 14 Is he / she currently undergoing treatment for any diseases or previously had any diseases listed below?  
 Roseola    Measles    Rubella    Mumps    Chicken pox    RS virus infection  
 Otitis media    Croup syndrome    Pneumonia / Bronchitis    Fever convulsion    Cystitis  
 Bronchial asthma    Allergic rhinitis    Urticaria    Allergic dermatitis  
 Others { \_\_\_\_\_ }
- 15 About his / her family  
Does anyone have allergic diseases?    No    Yes ⇒ Relationship { \_\_\_\_\_ } Diseases { \_\_\_\_\_ }  
Does anyone had have any serious diseases?  
 No    Yes ⇒ Relationship { \_\_\_\_\_ } Diseases { \_\_\_\_\_ }