Health check list

Please fill in at home and submit to the shelter reception.

Date of filling in	day/month/year	your temperature	℃
name		age	
Have you been vaccinated against pneumococcus?		yes / no / unknown	

Please check suitable items.

Questionnaire on zoning

1	☐	Have you been diagnosed as having contracted COVID-19 and are you confining yourself at home?
2	☐	Have you ever closely contacted a person who has been diagnosed with COVID-19? And are you under medical observation?
3	☐	Have you contacted a COVID-19 infected person during the past 14 days?
4	☐	Have you been to a COVID-19 pulluted area during the past 14 days?
5	☐	Have you ever run a fever higher than 37.5 degrees centigrade during a few days?
6	☐	Do you feel severely exhousted?
7	☐	Do you have difficulty in breathing, cough, raise, phlegm, or suffer from sore throat?
8	☐	Do you have difficulty in smelling or tasting?
9	☐	Are you suffering from any symptoms that you fear are related to COVID-19 virus?

Questionnaire on chronic illnesses and things to be taken into consideration

10	☐	Do you need any care or help?
11	☐	Are you a person with disabilities?
12	☐	Do you have an infant / infants? Are you pregnant?
13	☐	Are you suffering from respiratory diseases, diabetes, or any other chronic disease?
14	☐	What other physical or mental changes have you noticed?