Date: Year Month Day

Name: Sex:□Male □Female

Date of birth: Y/ M/ D Age: Native language:

Address: Occupation:

Tel: - - Height: cm Weight: kg

Car model (color): ( ) number:

What is the date of the symptom onset? いつから発症していますか？

Do you have any of the following signs and symptoms? 次のいずれかの症状はありますか？

fever（ ℃） / cough / sore throat / nasal discharge /shortness of breath / 発熱/咳/咽頭痛/鼻水/息切れ

chills / headache / muscle aches / vomiting / abdominal pain / diarrhea 悪寒/頭痛/筋肉痛/嘔吐/腹痛/下痢

taste abnormalities / olfactory abnormality / 味覚異常/嗅覚異常

In the 7days before symptom onset, 1 週間以内に、

Have you been in contact with someone who has Coronavirus (COVID-19)?

コロナウイルス感染者と接触しましたか？

□Yes/ □No

Have you ever received the COVID-19 vaccine before? 新型コロナワクチンの接種を受けたことはありますか？

□Yes : (times)

When was the last time you were vaccinated? : Y/ M/ D

(Pfizer or Moderna or others)

□No

Are you currently receiving medical treatment? □Yes ↓ □No 病気で病院にかかっていますか？

～List all the patient`s comorbid conditions～ 持病や患者の状態について

diabetes / cardiac disease / hypertension / chronic pulmonary disease / chronic kidney disease

chronic liver disease / immunocompromised / others

糖尿病/心疾患/高血圧/慢性肺疾患/慢性腎疾患 /慢性肝疾患/免疫不全/その他

Questions for Woman ① pregnancy 妊娠 □Yes: how many weeks □No

② feeding 授乳 □Yes □No

Currently do you smoke cigarettes? 現在タバコは吸いますか

□Yes □No

Do you have any allergies to food, medicine, etc.? 食べ物や薬のアレルギーはありますか？

□Yes □No

Do you take any medication? 定期薬はありますか？ なにを飲んでいますか？

□Yes : what medicine do you take?

□No