Dentistangpinoy.com

NAME OF CLINIC : _____

Assessment Questionnaire of Potential Risk Factors for 2019 Novel Corona Virus Infection		
Surname:		
Firstname:		
Date of Birth:	Age:	Sex: Ó Male Ó Female
Contact No.	Civil Status:	
Current Address:		
Country of Birth:		
Nationality:		
Occupation:		
Ó Student	Ó Healthcare personnel	
Risk Factor Questionnaire		
Travel History:		
Have you Ever Visited any country(ies) a month prior to your visit to our healthare Facility ?		
If Yes, specify country(ies) or City(ies) visited (from most recent)		
If Yes, when did you Arrive in the Philippines?		
Country	**City/ Region**	**Date Entered** **Date Departed**
Last		
Second		
First		
History of 2019 NCOV Exposure		
Have you had contact with pesons with confirmed case of Covid 19		
Persons under investigation (PUI)		
Persons under Monitoring (PUM)		
If Yes, how many times (total)		
If Yes, How long each time?		
Less than 5 minutes		
5-15 minutes		
More than 15 minutes?		
Face to face exposure		
Frae to face exposure with personal protective equipment		
What type of PPEs ?		
SYMPTOMS		
Have you ever experienced any respiratory symptoms (sorethroat, runny nose,cough, shortness of breath) prior to your visit to our health care facility ?		
YES NO		
If No, please skip the following questions		
If Yes, Date of onset of symptoms		
Fever YES NO UNKNOWN		
Please Indicate if you are experiencing the following Symptoms		
Sore Throat	YES NO	UNKNOWN
Cough	YES NO	UNKNOWN
Runny Nose	YES NO	UNKNOWN
Shortness of breath	YES NO	UNKNOWN
Other Symptoms		
Chills	YES NO	UNKNOWN
Nausea	YES NO	UNKNOWN
Diarrhea	YES NO	UNKNOWN
Headaches	YES NO	UNKNOWN
Joint Aches	YES NO	UNKNOWN
Muscle Aches	YES NO	UNKNOWN
General Malaise	YES NO	UNKNOWN
Loss of Appetite	YES NO	UNKNOWN
Other Symptoms not included in this List		
Please Specify		

Patient Name and Signature

_____

If Minor, Parent/Guardian Name and Signature

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