PCR Test Questionnaire

ID : _____

Body temperature: _____℃

Name: _____ Date of Birth: _____/_____/_____
(year) (Month) (day)

Residential Address: _____

Postal code: _____

Tel number: _____

Pre-existing medical conditions (if any): _____

Allergy: Yes / No (if Yes, please explain) _____

_____

Please check ALL THE CONDITIONS which may apply; SpO_2: _____%

☐Fever over 37.5℃
☐Fatigue (feeling of wariness/lack of energy)
☐Muscle pain
☐Chill
☐Cough
☐Difficulty breathing
☐Shortness of breath
☐Loss of taste
☐Loss of smell

Within the last 2 week-period of time, I have;
☐*exposed closely and heavily to someone who has tested positive for Covid-19.*
☐exposed to someone who might be positive for Covid-19.
☐overseas travel history

Vaccinated;

☐No / ☐Yes (☐1st dose / ☐ 2nd dose)

Date of sample collection: Year _____ month _____ day _____

Signature: _____

(if the recipient of the test is under age, parent / guardian can sign.)

Healthcare Corporation SKY
SKY Orthopedic Clinic