

ORMOC CITY COVID-19 HEALTH CHECKLISTS

PERSONAL DATA			
Name: <i>(Last Name, First Name, Middle Name)</i>			
Age:	Sex:	Civil status:	Nationality:
Contact number:		Email address:	
Present address:			
TRAVEL HISTORY			
<i>Please list down the 3 most recent places you visited before arriving in Ormoc City (within 30 days)</i>			
Name of Place Visited	Travel Date Period	Mode of Transportation	Plate No./Flight No.
1.			
2.			
3.			
MEDICAL HISTORY:			
Are you experiencing/suffering from any of the following symptoms? (within 14 days)			
FEVER	() YES () NO	In the course of your travel, do you think you were exposed to the COVID-19 virus? () YES () NO	
COUGH	() YES () NO		
SHORTNESS OF BREATH	() YES () NO		

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