11. Health observation sheet for individuals infected with Covid-19

HER-SYS ID:	Address:	TEL: - -	Email: @
Name:	Start date of recovery at home (MM/DD/YYYY):		

		Start date of recovery at home	DAY	DAY	DAY	DAY	DAY	DAY	DAY	DAY	DAY	DAY
Date and time of interview		/ :	/ :	/ :	/ :	/ :	/ :	/ :	/ :	/ :	/ :	/ :
		:	:	:	:	:	:	:	:	:	:	:
Body temperature		℃	℃	℃	℃	℃	℃	℃	℃	℃	℃	℃
		℃	℃	℃	℃	℃	℃	℃	℃	℃	℃	℃
Oxygen saturation (pulse oximeter)		%	%	%	%	%	%	%	%	%	%	%
		%	%	%	%	%	%	%	%	%	%	%
[Expression/appearance] ★The patient obviously has a poor complexion. ★The lips are purple. ★The patient appears to be different from usual or seems strange.		No/Yes	No/Yes	No/Yes	No/Yes	No/Yes	No/Yes	No/Yes	No/Yes	No/Yes	No/Yes	No/Yes
[Sputum/coughing] Coughing and sputum have been getting worse.		No/Yes	No/Yes	No/Yes	No/Yes	No/Yes	No/Yes	No/Yes	No/Yes	No/Yes	No/Yes	No/Yes
[Shortness of breath] ★My breathing has become rough. (The breathing rate has increased.) ★I suddenly felt short of breath. ★Slight activity in daily life results in breathlessness. ★I have chest pain. ★I cannot lie down. I have to sit to breathe. ★I am breathing heavily/wheezing.		No/Yes	No/Yes	No/Yes	No/Yes	No/Yes	No/Yes	No/Yes	No/Yes	No/Yes	No/Yes	No/Yes
[Body fatigue] It is painful to stay out of bed.		No/Yes	No/Yes	No/Yes	No/Yes	No/Yes	No/Yes	No/Yes	No/Yes	No/Yes	No/Yes	No/Yes
[Nausea/vomiting] I have been vomiting/I have chronic nausea.		No/Yes	No/Yes	No/Yes	No/Yes	No/Yes	No/Yes	No/Yes	No/Yes	No/Yes	No/Yes	No/Yes
[Diarrhea] I have diarrhea (three times or more a day).		No/Yes	No/Yes	No/Yes	No/Yes	No/Yes	No/Yes	No/Yes	No/Yes	No/Yes	No/Yes	No/Yes
[Impaired consciousness] ★The patient appears to be dazed (reaction is weak). ★The patient appears to be faint. (There is no response.) ★The pulse feels irregular and out of rhythm.		No/Yes /Unknown because I live alone	No/Yes /Unknown because I live alone	No/Yes /Unknown because I live alone	No/Yes /Unknown because I live alone	No/Yes /Unknown because I live alone	No/Yes /Unknown because I live alone	No/Yes /Unknown because I live alone	No/Yes /Unknown because I live alone	No/Yes /Unknown because I live alone	No/Yes /Unknown because I live alone	No/Yes /Unknown because I live alone
Other	I cannot eat meals.	No/Yes	No/Yes	No/Yes	No/Yes	No/Yes	No/Yes	No/Yes	No/Yes	No/Yes	No/Yes	No/Yes
	I have not urinated for half a day.	No/Yes	No/Yes	No/Yes	No/Yes	No/Yes	No/Yes	No/Yes	No/Yes	No/Yes	No/Yes	No/Yes
	Other symptoms (nasal mucus/stuffy nose, sore throat, conjunctival hyperemia, headache, joint/muscle pain, convulsions, other noticeable symptoms)	No/Yes	No/Yes	No/Yes	No/Yes	No/Yes	No/Yes	No/Yes	No/Yes	No/Yes	No/Yes	No/Yes
		(Specific symptoms)										
Symptoms												
Recommendation to receive an examination		Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No
Remarks												

Health center: Affiliation: TEL: FAX: