Date of consultation	/ /
Name of patient	
Date of birth	/ /
Sex	
Clinic ID number	

For follow up visit for the current symptom.
A. Please circle the symptoms he/she has **now**.

☐ Fever ☐ Cough ☐ Nasal discharge ☐ Wheezing
☐ Diarrhea ☐ Vomiting ☐ Rash ☐ Others（ ）

Pain :
☐ Headache ☐ Earache ☐ Sore throat
☐ Neck pain ☐ Chest pain ☐ Stomachache
☐ Joint pain ☐ Others（ ）

B. Is your child suspected of the infections below? Has he/she been in close contact with anyone who had these infections? Please circle if applicable.

☐ Influenza ☐ Pharyngoconjunctival fever ☐ Varicella
☐ Mumps ☐ Whooping cough ☐ COVID-19

C. Can he/she laugh, play, sleep, eat, or drink as usual? Please circle the most applicable number. 5 means 'can do as usual' and 1 means 'almost impossible'.

Laugh (5, 4, 3, 2, 1) Play (5, 4, 3, 2, 1) Sleep (5, 4, 3, 2, 1)
Eat (5, 4, 3, 2, 1) Drink (5, 4, 3, 2, 1)

D. Has he/she used the prescribed medicine since the last visit? Please circle if applicable.

☐ Mostly ☐ Sometimes ☐ Almost never

Thank you for filling out.