Health Monitoring Sheet for a COVID-19 Patient with Mild / No Symptoms (Sheet 1)

This is a questionnaire for health monitoring during home isolation. When you receive a daily phone call from a public health nurse, help the nurse to check your condition correctly.

If you have any worrying symptoms, be sure to contact the public health center ASAP.

If you answer Yes to any one of the symptoms indicated with ★, immediately contact the public health nurse, or anyone available at the center. (Contact phone number: xxx-xxxx)

Patient name:	Address:	TEL: ー ー	Email: @
	Home isolation start date: (MM/DD/YY)		

		Date	Monitoring start date	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7	Day 8	Day 9	Day 10
			/	/	/	/	/	/	/	/	/	/	/
Vital sign	8:00 a.m.	Body temperature	℃	℃	℃	℃	℃	℃	℃	℃	℃	℃	℃
Vital sign	6:00 p.m.	Body temperature	℃	℃	℃	℃	℃	℃	℃	℃	℃	℃	℃
Respiratory symptoms	1	Cough	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes
Respiratory symptoms	2	Breathing ★ Fast breathing (Breathing rate increasing) ★ Suddenly feeling short of breath ★ Feeling short of breath even during everyday activities ★ Chest pain ★ Inability to lie down / being able to breathe only while sitting up ★ Shoulders heaving while breathing / gasping for breath	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes
Respiratory symptoms	3	Runny / stuffy nose	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes
Respiratory symptoms	4	Facial expression / appearance ★ Lips turning purple	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes
Respiratory symptoms	5	Sore throat	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes
Others	6	Abnormal taste and smell	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes
Others	7	Nausea / vomiting	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes
Others	8	Conjunctival inflammation (Inflamed eyes)	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes
Others	9	Headache	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes
Others	10	Fatigue	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes
Others	11	Joint / muscle pain	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes
Others	12	Diarrhea	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes
Others	13	Impaired consciousness ★ Irregular pulse /unsteady pulse rate	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes
Others	14	Convulsion	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes
Others	15	Sleeplessness	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes
Others	16	Anxiety	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes
Others	17	Others	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes
Others	18	Bleeding (only for pregnant women)	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes
Others	19	Acute stomach pain (only for pregnant women)	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes
Did you check your symptoms in the morning or evening? Check the appropriate box as shown to the right. ☑			Morning: ☐( ) Evening: ☐( )	Morning: ☐( ) Evening: ☐( )	Morning: ☐( ) Evening: ☐( )	Morning: ☐( ) Evening: ☐( )	Morning: ☐( ) Evening: ☐( )	Morning: ☐( ) Evening: ☐( )	Morning: ☐( ) Evening: ☐( )	Morning: ☐( ) Evening: ☐( )	Morning: ☐( ) Evening: ☐( )	Morning: ☐( ) Evening: ☐( )	Morning: ☐( ) Evening: ☐( )
Remarks													

Health Monitoring Sheet for a COVID-19 Patient with Mild / No Symptoms (Sheet 2)

This is a questionnaire for health monitoring during home isolation. When you receive a daily phone call from a public health nurse, help the nurse to check your condition correctly.

If you have any worrying symptoms, be sure to contact the public health center ASAP.

If you answer Yes to any one of the symptoms indicated with ★, immediately contact the public health nurse, or anyone available at the center. (Contact phone number: xxx-xxxx)

Patient name:	Address:	TEL: ー ー	Email: @
	Home isolation start date: (MM/DD/YY)		

		Date	Day 11	Day 12	Day 13	Day 14	Day 15	Day 16	Day 17	Day 18	Day 19	Day 20
			/	/	/	/	/	/	/	/	/	/
Vital sign	8:00 a.m.	Body temperature	℃	℃	℃	℃	℃	℃	℃	℃	℃	℃
Vital sign	6:00 p.m.	Body temperature	℃	℃	℃	℃	℃	℃	℃	℃	℃	℃
Respiratory symptoms	1	Cough	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes
Respiratory symptoms	2	Breathing ★ Fast breathing (Breathing rate increasing) ★ Suddenly feeling short of breath ★ Feeling short of breath even during everyday activities ★ Chest pain ★ Inability to lie down / being able to breathe only while sitting up ★ Shoulders heaving while breathing / gasping for breath	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes
Respiratory symptoms	3	Runny / stuffy nose	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes
Respiratory symptoms	4	Facial expression / appearance ★ Lips turning purple	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes
Respiratory symptoms	5	Sore throat	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes
Others	6	Abnormal taste and smell	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes
Others	7	Nausea / vomiting	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes
Others	8	Conjunctival inflammation (Inflamed eyes)	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes
Others	9	Headache	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes
Others	10	Fatigue	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes
Others	11	Joint / muscle pain	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes
Others	12	Diarrhea	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes
Others	13	Impaired consciousness ★ Irregular pulse /unsteady pulse rate	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes
Others	14	Convulsion	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes
Others	15	Sleeplessness	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes
Others	16	Anxiety	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes
Others	17	Others	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes
Others	18	Bleeding (only for pregnant women)	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes
Others	19	Acute stomach pain (only for pregnant women)	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes	No / Yes
Did you check your symptoms in the morning or evening? Check the appropriate box as shown to the right. ☑			Morning: ☐( ) Evening: ☐( )	Morning: ☐( ) Evening: ☐( )	Morning: ☐( ) Evening: ☐( )	Morning: ☐( ) Evening: ☐( )	Morning: ☐( ) Evening: ☐( )	Morning: ☐( ) Evening: ☐( )	Morning: ☐( ) Evening: ☐( )	Morning: ☐( ) Evening: ☐( )	Morning: ☐( ) Evening: ☐( )	Morning: ☐( ) Evening: ☐( )
Remarks												