HEALTH DECLARATION

St. Luke's Medical Center EXTENSION CLINIC

Due to the recent worldwide outbreak of COVID-19, St. Luke's Medical Center Extension Clinic would like to ensure that our patients/customers and employees are safe from exposure to the disease. In line with this, we are requesting all patients, including companions and visitors, to complete this form.

The data that you provide is strictly confidential and used for hospital reference only.

Name: _____ Age:____ Sex:____ Contact No.: _____
I am a [ ] Patient [ ] Visitor [ ] Companion [ ] Others_____

Please tick an answer for every question item	YES	NO
Have you been tested for COVID-19 in the last 2 weeks? Date swabbed: Result (if available):		
Have you been evaluated as Probable or Suspected for COVID-19? If YES, when did your quarantine start?		
Did you have any travel history in the past 14 days? If YES, when and where?		
Did you come in close contact or are you staying in the same close environment with someone who is a confirmed COVID-19 case?		
Have you experienced any of the following symptoms in the last 2 weeks? Fever (>38°C)		
Diarrhea, Nausea, or Vomiting		
Shortness of breath or other respiratory symptoms		
Other respiratory symptoms:		
Headache		
Joint Pain or Muscle Pain		
Flu-like symptoms such as: Chills or repeated shaking with chills		
Body aches		
Sore throat		
Runny Nose or Sneezing		
Cough and colds		
Loss of smell and/or taste		
Eye discharge		
Skin rash or discoloration of toes/fingers		
Loss of speech or movement		

I agree that the information provided in this document is true and correct to the best of my knowledge and understand that any dishonest answers may have serious legal and public health implications under RA 11332.

I declare that all information disclosed above is TRUE and CORRECT.

Signature: _____ Date:_____

Approved entry by: _____ Referred to:_____
(Name & signature of associate)

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