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	**NO**	**YES**
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, have you completed your isolation period?		
Did you come in close contact or are you staying in the same close environment with someone who is a confirmed COVID-19 case? [ ] Relative [ ] Workplace [ ] Household When: _____		

Do you have any of the following symptoms?	**NO**	**YES**	**Date Experienced**
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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