

Name: _____ Age: _____ Sex: Male/Female

Q1: Residence Address _____

Q2: Since how many days you are staying at above address: _____

Q3: Did you have any contact with patient of cough/cold/fever/body pain? Yes/No

If yes, give details

Q4: Do you have or suffered from any of the symptoms mentioned below in last two weeks?

If YES, mark Tick (v) If NO, mark cross (X)

- a. Cough b. Cold c. Fever d. Body pain

Q5: Do you have any of the co-morbid conditions like, Diabetes mellitus, Hypertension, COPD, Cancer, Kidney & Heart diseases *(If yes, the Doctor should be extra careful in certifying such persons)*

Q6: Did you have any contact with a foreigner / travel abroad in last two weeks? If YES give details.....
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Q7: Mode of travel that you use within city a. Public (self/public transport) b. Private

Dated:

Signature of visitor

Time:

Mobile No.

FIT/UNFIT

(To be certified by the Registered Medical Doctor)