

QUESTION - Within the past 14 days, have you...

YES NO
はい いいえ

Had close contact with anyone diagnosed as having Coronavirus disease COVID-19?			
COVID-19に罹患したと診断された人と濃厚接触しましたか			
Provided direct care for COVID-19 patients?			
COVID-19患者を直接看病しましたか			
Visited or stayed in a closed environment with any patient having Coronavirus disease COVID-19?			
COVID-19に罹患した患者がいた密閉環境を訪れたり滞在したことがありますか			
Worked together in close proximity, or sharing the same classroom environment with COVID-19 patient?			
COVID-19の患者と至近距離で仕事をするか、あるいは同じ教室にいましたか			
Traveled together with COVID-19 patient in any kind of conveyance?			
COVID-19の患者と何らかの乗り物に同乗しましたか			
Lived in the same household as a COVID-19 patient?			
COVID-19の患者と同居しましたか			
Been in quarantine?			
隔離されていませんか			
Tested positive to the swap PCR test?			
PCR検査で陽性になったことがありますか			
Experienced any of the following symptoms now and in the previous 14 days:			
過去14日間及び現在における以下の症状の有無			
• Fever 熱			
• Cough 咳			
• Fatigue 疲れ			
• Dyspnea 呼吸困難			
• Myalgia 筋肉痛			
• Sore Throat 喉の痛み			
• Chest Pain 胸の痛み			
• Congestion/Coryza 鼻つまり/鼻かぜ			
• Headache 頭痛			
• Chills 悪寒			
• Nausea/Vomiting 吐き気/吐血			
• Diarrhea 下痢			
• Anosmia/Dysgeusia 嗅覚障害/味覚障害			
• Chiliblains/Pernio 霜焼け			

