



GUEST RISK FACTOR IDENTIFICATION QUESTIONNAIRE

Name/ Last name				Nationality/Country	
Date of birth	/ /	Age		Gender / Sex	Female <input type="radio"/> Male <input type="radio"/>
Hotel/Lobby				Room	
Way of transportation	Arrival	/ /	Check Out	/ /	
Air <input type="radio"/>	Land <input type="radio"/>	Sea <input type="radio"/>			
Origin city of flight: _____ Flight No.: _____ Airline: _____ Layovers: _____					

Do you currently have an illness or disease?	Yes <input type="radio"/>	No <input type="radio"/>	If yes, what?:
Are you pregnant?	Yes <input type="radio"/>	No <input type="radio"/>	
Do you have high blood pressure, heart or respiratory problems, or diabetes?	Yes <input type="radio"/>	No <input type="radio"/>	
Are you currently taking any medication?	Yes <input type="radio"/>	No <input type="radio"/>	If yes, what medication?:

Have you had direct contact with a positive patient confirmed with COVID-19?	Yes <input type="radio"/>	No <input type="radio"/>	I don't know <input type="radio"/>		
Have you experienced the following symptoms in the last 14 days?	Yes <input type="radio"/>	No <input type="radio"/>			
Fever <input type="radio"/>	Cough <input type="radio"/>	Sore throat <input type="radio"/>	Headache <input type="radio"/>	Fatigue <input type="radio"/>	Diarrhea <input type="radio"/>
Short of breath (that is not being caused by any chronic or previously diagnosed disease) <input type="radio"/>					
Chest pain <input type="radio"/>	Conjunctivitis <input type="radio"/>	Muscle pain <input type="radio"/>	Vomiting <input type="radio"/>		
Eye pain <input type="radio"/>	Chest pain <input type="radio"/>	Earache <input type="radio"/>	Articulations pain <input type="radio"/>		
Difficulty breathing <input type="radio"/>	Sweating <input type="radio"/>	Runny nose <input type="radio"/>	Itch <input type="radio"/>	Fever of 37.5 °C <input type="radio"/>	
Has anyone in your family or friends experienced any of these symptoms?	Yes <input type="radio"/>	No <input type="radio"/>			
If you checked yes to any of the above, have you received medical treatment for the symptoms?					
YES, IT IS WORKING <input type="radio"/>	YES, BUT IT IS NOT WORKING <input type="radio"/>	NO <input type="radio"/>			

