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| 1 Do you have symptoms such as fever, cough, sneezing, sore throat, fatigue, sense of smell, changes in taste, and body aches? | Yes/no |
| 2. Do you have difficulty of breathing? | Yes/no |
| 3. Have you travelled outside the country in the last 30 days?  If yes, then write the name of the country\_\_\_\_\_\_\_ | Yes/no |
| 4. Have you traveled to other cities in India in 15 days?  If yes, write the name of the city\_\_\_\_\_\_\_ | Yes/no |
| 5. Were you a Covid-19 positive patient in the last two weeks? or suspect in a case of covid-19 ? | Yes/no |
| 6. Have you visited a health care facility in the past two weeks? | Yes/no |