



EPIDEMIOLOGICAL SURVEY

Viral Respiratory Disease

Full name: _____ Nationality/Country: _____

Date of birth: ____ / ____ / ____ Age: _____ Gender: _____

Mode of transport: Airplane _____ Land _____ By sea _____

Arrival: ____ / ____ / ____ Departure: ____ / ____ / ____ Travel agency: _____

Traveling alone?: Yes No Family _____ Friends _____

Do you have health insurance? Yes No What kind? _____

Have your friends or family had similar symptoms to yours today? Yes No

In the past 24 hours, have you experienced any of the following symptoms?

Symptom	Yes	No
Fever	<input type="checkbox"/>	<input type="checkbox"/>
Cough	<input type="checkbox"/>	<input type="checkbox"/>
Throat pain	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty breathing	<input type="checkbox"/>	<input type="checkbox"/>
Headache	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>
Muscle aches or pains	<input type="checkbox"/>	<input type="checkbox"/>
Joint pain	<input type="checkbox"/>	<input type="checkbox"/>
General discomfort	<input type="checkbox"/>	<input type="checkbox"/>
Runny nose	<input type="checkbox"/>	<input type="checkbox"/>
Conjunctivitis	<input type="checkbox"/>	<input type="checkbox"/>
Changes to your sense of taste/smell	<input type="checkbox"/>	<input type="checkbox"/>

Do you have any of the following?	Yes	No
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Obesity	<input type="checkbox"/>	<input type="checkbox"/>
Any condition that makes you immune compromised	<input type="checkbox"/>	<input type="checkbox"/>

I declare, to the best of my ability, that all the information provided through this form is true and complete, including that it is written by me. I declare that I have not omitted, changed, or falsified any important clinical fact. I declare that I am aware of the Covid-19 pandemic and the state of “new normal” in Mexico, as well as the existing contagion risks of Covid-19. I agree to follow all sanitary protocols and regulations implemented by the management during my stay at Hotel Villa Varadero, without holding responsible Nuevo Vallarta Menhir S.A. de C.V. or any of its employees or vendors.

Full name and signature

Date