Urgent Care Center
MEDSTOP
Madonna Plaza SLO

PATIENT HISTORY FORM
SARS-CoV-2 (COVID-19) TESTING

Information below is required by the US Health and Human Services (HHS) Department, CDC, and California Public Health Department (CDPH)

PATIENT INFORMATION

_____ _____ _____
Last Name First Name Date of Birth

RACE:

☐ American Indian or Alaskan Native (AI)
☐ Native Hawaiian or Other Pacific Islander (PI)
☐ Asian (AS)
☐ White (W)
☐ Black or African American (B)
☐ Multiple/Other (O)

ETHNICITY:

☐ Hispanic/Latino (H)
☐ Non-Hispanic/Latino (N)

OCCUPATION: _____

☐ Essential Worker
☐ Non-Essential Worker
☐ Unknown

COVID-19 CLINICAL HISTORY

Vaccinated?	☐ YES	☐ NO	
	DATE: 1st dose _____	2nd dose _____	
Reason for current testing?	☐ Illness	☐ Exposure	☐ Pre-op
	☐ Travel	☐ School	☐ Work requirement
	Other: _____		
First Test?	☐ YES	☐ NO	☐ UNKNOWN
Employed in Healthcare?	☐ YES	☐ NO	☐ UNKNOWN
Symptomatic as defined by CDC?	☐ YES	☐ NO	☐ UNKNOWN
Date of onset: _____			
Hospitalized for COVID-19?	☐ YES	☐ NO	☐ UNKNOWN
ICU for COVID-19?	☐ YES	☐ NO	☐ UNKNOWN
Resident in a congregate care setting?	☐ YES	☐ NO	☐ UNKNOWN
Pregnant?	☐ YES	☐ NO	☐ UNKNOWN

PROVIDER REVIEWED: _____