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 (Al) ☐ 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 _____	
	☐ Pfizer	☐ Moderna	☐ Johnson & Johnson
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

EMAIL ADDRESS: _____