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 _____ BOOSTER: _____

☐ Pfizer ☐ Moderna ☐ Johnson & Johnson

Reason for current testing? ☐ Illness ☐ Exposure ☐ Pre-op

☐ Travel ☐ School ☐ Work requirement

Other: _____

Employed in Healthcare? ☐ YES ☐ NO ☐ UNKNOWN

Symptomatic of COVID? ☐ YES ☐ NO ☐ UNKNOWN

Date of onset: _____

Previous COVID disease? ☐ YES ☐ NO WHEN: _____

Resident in a congregate care setting? ☐ YES ☐ NO ☐ UNKNOWN

Potentially pregnant? ☐ YES ☐ NO ☐ UNKNOWN

EMAIL ADDRESS: _____