Patient History Form
SARS-CoV-2 (COVID-19) Testing

All information below is **required** by the U.S. Health and Human Services (HHS) Department and Centers for Disease Control (CDC).

CLINICAL PATHOLOGY LABORATORIES
A Sonic Healthcare Company

PATIENT INFORMATION

Patient Name _____ _____ _____ Date of Birth _____

Last Name *First Name* *M.I.*

Patient Race

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

Patient Ethnicity

- ☐ Hispanic/Latino (H)
- ☐ Non-Hispanic/Latino (N)
- ☐ Unspecified/Not Given/Refused (U)

COVID-19 CLINICAL HISTORY

First Test?	☐ YES	☐ NO	☐ UNKNOWN
Employed in Healthcare?	☐ YES	☐ NO	☐ UNKNOWN
Symptomatic as defined by CDC?	☐ YES	☐ NO	☐ UNKNOWN
If yes, then date of symptom onset (mm/dd/yy): _____			
Hospitalized for COVID-19?	☐ YES	☐ NO	☐ UNKNOWN
ICU for COVID-19?	☐ YES	☐ NO	☐ UNKNOWN
Resident in congregate care setting?	☐ YES	☐ NO	☐ UNKNOWN
Pregnant?	☐ YES	☐ NO	☐ UNKNOWN