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).

ProMedica Pathology Laboratories
A Partnership of ProMedica and Sonic Healthcare

COVID-19 FORM 02

HOW TO PROPERLY FILL OUT THIS FORM

CORRECT WAY:

- Fill circle all the way
- No marks outside of the lines
- Use a black ink pen

UNACCEPTABLE WAYS:

PATIENT INFORMATION

Patient Name

Patient Phone # _____ – _____ – _____

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

ACCESSION LABEL