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).

PATHOLOGY LABORATORIES
A Sonic Healthcare Clinical Laboratory

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)   ○ Native Hawaiian or Other Pacific Islander (PI)

○ Asian (AS)   ○ White (W)

○ Black or African American (B)   ○ 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