COVID-19 Test: Please complete all sections and sign at the end.

Patients must be 18 years or older to take a COVID-19 test.

Patients below 18 years of age must be accompanied by a parent or legal guardian.

Have you experienced any of these symptoms? (Select any that apply)

- ☐ Fever
- ☐ Cough
- ☐ Nausea or vomiting
- ☐ Diarrhea
- ☐ Congestion or runny nose
- ☐ New loss of taste or smell
- ☐ Chills
- ☐ Sore throat

- [ ] Headache
- [ ] Fatigue
- [ ] Muscle or body aches
- [ ] Shortness of breath or difficulty breathing

Do you have any of the following medical conditions? (Select any that apply)

- [ ] Asthma or chronic lung disease
- [ ] Cirrhosis of the liver
- [ ] Diseases or conditions that make it harder to cough
- [ ] Diabetes
- [ ] Pregnancy
- [ ] Kidney failure or end stage renal disease
- [ ] Extreme obesity
- [ ] Serious heart condition, such as congestive heart failure
- [ ] Conditions that result in a weakened immune system, including cancer treatment

Have you been prioritized for testing by a medical professional?

○ Yes ○ No

In the past 14 days, have you had known or suspected exposure to the SARS-CoV-2 virus or a COVID-19 patient? (e.g. been exposed to someone with COVID-19 or been in

a large public gathering where exposure is suspected)

○ Yes ○ No

Have you previously tested positive for COVID-19?

○ Yes ○ No

Do you live or work in a special setting where the risk of COVID-19 transmission may be high? (This may include long-term care, correctional and detention facilities; homeless shelters; assisted-living facilities and group homes.)

○ Yes ○ No

☐ I acknowledge that I have answered these questions truthfully to the best of my knowledge. I

Name:	DOB:
Signature:	Date: