Oregon Health Authority/Center for Disease Control and Prevention (CDC) Coronavirus (COVID-19) Testing Questionnaire

Patient Name:_____

Patient Date of Birth:_____/_____/_____

Date of Symptoms (if applicable):_____

Patient Employed in Healthcare Field? Yes / No

Is this the 1st COVID-19 test that you have received? Yes / No

Is this test being completed for an upcoming procedure? Yes / No

Are you currently pregnant? Yes / No / Not applicable

Do you currently reside in a Support Care facility? Yes / No

Do you currently have any symptoms of the COVID-19 virus? Yes / No

Is this test being completed for travel purposes? Yes / No