FOXHALL
INTERNISTS, PC

Date _____

We are required by the D.C. Health Department to provide them with the following information with each test for COVID-19 collected in our lab. Kindly complete this form in advance of your testing appointment and bring it with you.

Name _____ County of Residence _____

Address _____ Contact phone number (_____) _____

_____ Signature _____

1. Is this your first test for COVID-19?
   ☐ Yes ☐ No

2. Are you employed in healthcare?
   ☐ Yes ☐ No

3. Do you currently have symptoms of a COVID-19 infection?
   ☐ Yes ☐ No

4. If yes, what day did your symptoms begin? _____ (MM/DD/YYYY)

5. Have you been hospitalized for a COVID-19 infection?
   ☐ Yes ☐ No

6. If yes, did you require care in the ICU?
   ☐ Yes ☐ No

7. Have you lived in a congregate care home this year? (examples include group homes, residential care facilities, or maternity homes)
   ☐ Yes ☐ No

8. Are you pregnant?
   ☐ Yes ☐ No

9. Race
   ☐ Asian ☐ Black or African American ☐ American Indian or Alaska native
   ☐ Native Hawaiian or other Pacific Islander ☐ White
   ☐ Other/not given

10. Ethnicity?
    ☐ Hispanic ☐ Non-Hispanic ☐ Not Given