



100 E Cypress Ave. Redding, CA 96002
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Patient Demographics

Name _____

Date of Birth _____

Address _____

Phone Number _____

County _____

Email _____

Race: _____ Ethnicity: _____

Symptoms (check if applicable):

Date of onset _____

- Fever/Chills (Temp. greater than 100.4)
- Subjective fever
- Cough
- Shortness of breath
- Fatigue
- Muscle aches/Body aches
- Conjunctivitis

- Headache
- Abdominal Pain
- Nausea/vomiting
- Diarrhea
- Sore throat
- Runny nose/Congestion
- New olfactory and taste disorder

Occupation/Where? _____

Provider name _____

Any chronic health conditions: _____

Provider phone number _____

Have you spoken to or seen your provider?

When? _____

Have you visited an Urgent Care or ER? Y or N

Smoker? _____

Are you pregnant? Y or N Due Date _____

Exposure to a + Covid? _____

Connected to School? Y or N School: _____

Date of exposure _____

Travel (within 14 days of illness)

Testing

Travel dates and locations _____

Chest x-ray? Y or N

Diagnosed with Pneumonia? Y or N

Any previous testing for Covid? Y or N

Public Health Action Taken: _____

Flu testing Y or N Result + -

Strep testing Y or N Result + -

Candidate for testing? Yes No

Other testing? _____

Physician Signature: _____ Date: _____ Time: _____