**Newtown Center Pediatrics**
**Dr. Laura Nowacki**
**10 Queen Street**
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| **Collection Date:**____/____/____<br>**First Name:**______________________________<br>**Last Name:**______________________________<br>**Date of Birth:**_____/_____/_____ **Age:**_____<br>**State of Residence:**_______________________<br>**County of Residence:**_____________________ | **Sex:**<br>☐ Male ☐ Female<br><br>**Pregnant?**<br>☐ Yes ☐ No ☐ Unk | **Ethnicity:**<br>☐ Hispanic/Latino<br>☐ Non-Hispanic/Latino | **Race:**<br>☐ Black ☐ White ☐ Asian<br>☐ American Indian/Alaska Native<br>☐ Native Hawaiian/Other Pacific Islander<br>☐ Unknown ☐ Other _____________ |
|---|---|---|---|

**Which would best describe where the patient was staying at the time of testing?**
☐ Single Family Home ☐ Hotel/Motel ☐ Acute Care Inpatient Facility ☐ Dormitory ☐ Psychiatric Facility ☐ Other__________________

**Is the patient a health care worker?** ☐ Yes ☐ No ☐ Unknown
☐ First Responder ☐ Environmental Staff ☐ Other_____________________

**Is this the first test the patient has had?** ☐ Yes ☐ No
**If No, what type of test was the most recent test?** ☐ Molecular ☐ Antigen ☐ Antibody ☐ Unknown
**Result** ☐ Detected ☐ Not Detected
**Test Performed Date:** _____/_____/_____

**Is the patient experiencing any symptomatic illness symptoms?** ☐ Symptomatic ☐ Asymptomatic
**If symptomatic, which of the following symptoms:**

| Symptom | | | **Start Date** | Symptom | | | **Start Date** |
|---|---|---|---|---|---|---|---|
| **Fever > 100.4F** | ☐ Yes | ☐ No | | **Cough** | ☐ Yes | ☐ No | |
| **Shortness of Breath or Difficulty Breathing** | ☐ Yes | ☐ No | | **Fatigue** | ☐ Yes | ☐ No | |
| **Muscle or body aches** | ☐ Yes | ☐ No | | **Headache** | ☐ Yes | ☐ No | |
| **New loss of taste or smell** | ☐ Yes | ☐ No | | **Sore throat** | ☐ Yes | ☐ No | |
| **Congestion** | ☐ Yes | ☐ No | | **Nausea or vomiting** | ☐ Yes | ☐ No | |
| **Diarrhea** | ☐ Yes | ☐ No | | **Abdominal pain** | ☐ Yes | ☐ No | |