TCLS

TENNESSEE COMPREHENSIVE LUNG & SLEEP CENTER

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Board Certified in Pulmonary, Critical Care & Sleep Medicine

COVID-19 Patient History Form

Last Name _____ First Name _____ M.I. _____ Date of Birth _____

Phone Number _____

Patient Race (Please circle one)

- American Indian or Alaskan Native
- Asian
- Black or African American
- Native Hawaiian or Pacific Islander
- White
- Multiple/Other

Patient Ethnicity (Please circle one)

Hispanic/Latino

Non-Hispanic/Latino

COVID-19 Clinical History

First Test	Yes	No	Unknown
Employed In Healthcare	Yes	No	Unknown
Exposed to COVID Positive Individual	Yes	No	Unknown
Symptomatic As Defined By CDC	Yes	No	Unknown
If yes, then date of symptoms onset	Month/Date/Year	_____	
Fever	Yes	No	Unknown
Cough	Yes	No	Unknown
Shortness of Breath or Difficulty Breathing	Yes	No	Unknown
Fatigue	Yes	No	Unknown
Muscle or body aches	Yes	No	Unknown
Headache	Yes	No	Unknown
New Loss of Smell or taste	Yes	No	Unknown
Sore Throat	Yes	No	Unknown
Congestion	Yes	No	Unknown
Nausea or vomiting	Yes	No	Unknown
Diarrhea	Yes	No	Unknown