Florida Laboratory Analysis

6900 Southpoint Drive North, Suite 220
Jacksonville, FL, 32216
(407) 636-3939

Date: ___/ ___/ _____

Emergency COVID-19 Testing Data Report

Name: _____
Address: _____
Address: _____
City: _____ County: _____ State: ____ ZIP: _____
DOB: _____ Telephone: _____ DL number: _____
Race: _____Email:_____
Ethnicity:_____

Are you here by the request of an employer? ◯Yes ◯No Employer:_____

In the past 24 hours have you had a fever? : _____ Tempertature:_____

In the past 7 days have you had a cough or shortness of breath that is getting worse?: _____

In the past 3 days have you had any of the following symptoms?:

- ☐ Congestion or Runny nose
- ☐ Fatigue
- ☐ Muscle or body aches
- ☐ Sore throat
- ☐ Diarrhea
- ☐ Headache
- ☐ Shortness of breath or difficulty breathing
- ☐ Loss of taste or smell
- ☐ Joint Pain
- ☐ General feeling of discomfort
- ☐ Cough
- ☐ Nausea or vomiting

Do you currently have a sore throat?: ◯ Yes ◯ No

Do you currently have a runny nose?: ◯ Yes ◯ No

Do you currently have nasal congestion?: ◯ Yes ◯ No

In the past 14 days have you had close contact with someone diagnosed with COVID 19?: ◯ Yes ◯ No ◯ unknown

If yes were you wearing a face covering?: ◯ Yes ◯ No

Are you taking Asprin or Tylenol?: ◯ Yes ◯ No

Recent travel history:_____

PATIENT NAME:_____ SIGNATURE:_____