

|  |
| --- |
| **Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Health Care Provider Information**Name (First, Last): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Practice Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Practice Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Patient Information**Name (First, Last): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_ Gender \_\_\_\_\_\_ Race \_\_\_\_\_\_\_Pregnant \_\_\_\_\_\_\_\_\_\_ Gestational age (in weeks) \_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Travel and Potential Flavivirus Exposure** |
| **I would like to ask you about if you might have been exposed to Zika virus or related viruses before.** |
| **Did you travel outside the United States (or to a US territory: Puerto Rico, USVI, Am Samoa) in the last two weeks?** 🞏 Yes 🞏 No  **or in the last six months?**  Yes  No  |
| If yes:  | Name of country(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dates of travel: Start date:\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ End date: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ |
|  | Name of country(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dates of travel: Start date:\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ End date: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ |
|  | Name of country(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dates of travel: Start date:\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ End date: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ |
| **Medical Information** |
| **[In the past month], have you had any of these symptoms? New for you, not long standing problems.** |
| **Fever** 🞏 Yes 🞏 No If yes, first date with this \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ How many days did it last? \_\_\_\_\_\_\_\_*(report of subjective fever is acceptable)*  |
| **Rash**  🞏 Yes 🞏 No If yes, first date with this \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_How many days did it last? \_\_\_\_\_\_\_\_Was the rash itchy? 🞏 Yes 🞏 No*(NOT asking about localized rash or secondary to topical exposures)* |
| **Conjunctivitis** (*not allergic type*) 🞏 Yes 🞏 No  If yes, first date with this \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ How many days did it last? \_\_\_\_\_\_\_\_ |
| **Joint Pain** 🞏 Yes 🞏 No If yes, first date with this \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ How many days did it last? \_\_\_\_\_\_\_\_*(NOT chronic or post-trauma pain)* |
| **For this illness, did you go to a clinic/hospital to be checked?** 🞏 Yes 🞏 No **If yes, what did the doctor/nurse decide that you had?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Other exposures** |
| **In the last month, have you had sex with someone who had recently returned from a country where Zika has been spreading?** (By recently returned, we mean your partner had returned sometime during the 2 months *before* the time you had sex) **Your Answer** 🞏 Yes 🞏 No 🞏 Unknown If yes, gestational age (in weeks) |
| *For females:* Are you pregnant or think you might be pregnant?🞏 Yes 🞏 No 🞏 Unknown  |

**Version 1.0 8/2016**