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| **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 | | |

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