Travel-Associated Illness Screening Form

Completed By:_____ **Date:** ____/____/20___

Name of caller: _____ **Phone #**: ( ) ___-_____ **Facility**: _____

Patient Name: (Last) _____ (First) _____(MI)_____
Race: ☐White ☐Black ☐Asian ☐Other: _____ **Ethnicity**: ☐Hispanic ☐Non-Hispanic
DOB: ___/___/_____ Age: _____ **Sex**: ☐Male ☐Female ***If female, pregnant?*** ☐Yes ☐No
Address: _____ **City**: _____ **State**_____
Zip Code: _____ **County of Residence**: _____ **Phone #:** ( ) _____-_____

If pregnant: **EDC: (due date):** ___/___/20___ **LPM (1st day of last menstrual period):** ___/___/20____
OB/GYN Name: _____ **Phone #:** ( ) ____-_____

Patient Exposure Information

Country of Travel	From	Until	Purpose of Travel

Other Potential Exposures
☐Sexual transmission ☐Organ/tissue transplant transmission ☐Congenital ☐Other:

Date seen by physician: ___/____/20___ **Symptom onset date**: ___/____/20__
Have symptoms resolved? ☐Yes ☐No *If yes, when*? ___/____/20___

Was patient hospitalized for this illness? ☐Yes ☐No *If yes, hospital name:*_____
Admit date: __ / __ / ____ **Discharge date**: __ / __ / ____
Did patient die of illness? ☐Yes ☐No *If yes, when*? ___/____/20___

SIGNS AND SYMPTOMS
☐ Fever (Highest recorded temperature: _____ °F) (Duration of fever: ____ days)
☐ Rash(check type: ☐ maculopapular ☐ petechial ☐ purpuric ☐ pruritic)
☐ Myalgia (muscle aches) ☐ Arthralgia (joint aches) ☐ Headache ☐ Vomiting ☐ Diarrhea
☐ Conjunctivitis ☐ Rapid, weak pulse ☐ Bleeding gums
☐ Blood in vomitus/urine/stool ☐ Epistaxis (nose bleed) ☐ Ascites (fluid in abdomen)
☐ Retro-orbital or ocular pain (pain behind the eyes) ☐ Age-specific hypotension (low blood pressure)
☐ Other: _____

Does the patient have: *(check box if yes; leave unchecked if no)*
☐ Leukopenia (low white cell count)
☐ Hypoalbuminemia (low protein count) *Specify*: _____ *Normal value in your lab:* _____
☐ Hemoconcentration (high red blood cell/hemoglobin) *Specify*: _____
☐ Thrombocytopenia (low platelets)
☐ Hypoproteinemia (low protein) *Specify*: _____

Laboratory Testing
Malaria: ☐Positive ☐Negative ☐Not tested Yellow fever: ☐Positive ☐Negative ☐Not tested
Influenza: ☐Positive ☐Negative ☐Not tested Other: _____ ☐Positive ☐Negative ☐Not tested

Previous Vaccination(s): ☐Yellow Fever ☐Japanese Encephalitis ☐Tick-borne Encephalitis

Additional comments: _____
_____
_____
_____

Please fax to Division of Infectious Disease Epidemiology (DIDE) Zika Surveillance at (304) 558-8736.
Questions? Call (304) 558-5358, ext 1, (304) 423-1271, ext. 1, or our answering service at (304) 925-9946.