

# Travel-Associated Illness Screening Form

Completed By: \_\_\_\_\_

Date: \_\_\_/\_\_\_/20\_\_

Name of caller: \_\_\_\_\_ Phone #: ( ) \_\_\_ - \_\_\_\_\_ Facility: \_\_\_\_\_

<b>Patient Name:</b> (Last) _____ (First) _____ (MI) _____		
<b>Race:</b> <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Other: _____	<b>Ethnicity:</b> <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	
<b>DOB:</b> ___/___/___ Age: _____	<b>Sex:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>If female, pregnant?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Address:</b> _____	<b>City:</b> _____	<b>State:</b> _____
<b>Zip Code:</b> _____	<b>County of Residence:</b> _____	<b>Phone #:</b> ( ) ___ - _____
<b>If pregnant:</b> EDC: (due date): ___/___/20__ LPM (1 <sup>st</sup> day of last menstrual period): ___/___/20__		
<b>OB/GYN Name:</b> _____ <b>Phone #:</b> ( ) ___ - _____		

## 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.