Exposure Questionnaire

Date:_____

Patient Information:
Name (First, Last) _____Age_____DOB_____Race_____

This is a screening to determine exposure to or illness from COVID-19 or Zika virus.

Did you travel outside or within the US in the last 2 weeks? Yes_____ NO _____
In the last 6 months? Yes_____ No_____

If yes, please list travel below:

1. Location of travel, Country and City _____ Dates _____
2. Location of travel, Country and City _____ Dates _____

In the past Month – Have you had any symptoms listed below that are new to you, not long standing problems?

Fever

Yes_____ No_____ If yes, first date with this __/__/__ How many days did it last?_____
What was your temperature?_____

Rash

Yes_____ No_____ If yes, first date with this __/__/__ How many days did it last?_____
(Not asking about localized rash or secondary to topical exposure)

Conjunctivitis (Pink Eye)

Yes_____ No_____ If yes, first date with this __/__/__ How many days did it last?_____
(NOT Allergic type)

Joint Pain

Yes_____ No_____ If yes, first date with this __/__/__ How many days did it last?_____
(**Not Chronic or post-trauma pain)**

Cough

Yes_____ No_____ If yes, first date with this __/__/__ How many days did it last?_____

Difficulty Breathing

Yes_____ No_____ If yes, first date with this __/__/__ How many days did it last?_____

Sore Throat

Yes_____ No_____ If yes, first date with this __/__/__ How many days did it last?_____ _____

For this/these symptoms, did you go to a clinic/hospital to be evaluated?
Yes_____ No _____
If yes, what were you told that you had?_____

Other Exposure
During this pregnancy, have you had sex with someone who had recently returned from a country where Zika has been spread? (By recently returned, we mean your partner had returned sometime within the last 6 months before you had sex)
Yes_____ No _____ Unknown _____ If yes, gestational age (in weeks)_____