NEDSS ID: Testing Approved ☐ Yes ☐ No

Approved by

MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Zika Virus Interim Surveillance Form

PERSON COMPLETING FORM (date form completed: / /)

Name	Affiliation
Phone	FAX

PATIENT INFORMATION

Last	First	MI
DOB	Age	Sex ☐ Male ☐ Female
Street	City	State and Zip
Phone 1	Phone 2	County

Hispanic/Latino	☐ Yes ☐ No ☐ Unknown			
Race (select all that apply)	☐ American Indian/Alaska Native	☐ Asian	☐ Black/African American	
	☐ Native Hawaiian/other PI	☐ White	☐ Unknown	☐ Other

CLINICAL INFORMATION

Symptoms? ☐ Yes	☐ No (asymptomatic) ☐ Unknown		Date of onset:	
Hospitalized? ☐ Yes, hospital:			☐ No ☐ Unknown	
Admission date: / /			Discharge date: / /	
Outcome	☐ Survived	☐ Died	☐ Unknown	
Autopsy performed?	☐ Yes	☐ No	☐ Unknown	

SYMPTOMS AND CLINICAL SYNDROME

Fever	☐ Yes, temp:		☐ No ☐ Unknown		
Rash	☐ Yes ☐ No ☐ Unknown				
Rash pruritic (itchy)?	☐ Yes ☐ No ☐ Unknown				
Rash description	☐ Macular	☐ Papular	☐ Petechial	☐ Purpuric	☐ Other
Rash distribution:					

Conjunctivitis	☐ Yes ☐ No ☐ Unknown	Myalgia	☐ Yes ☐ No ☐ Unknown
Arthralgia	☐ Yes ☐ No ☐ Unknown	Vomiting	☐ Yes ☐ No ☐ Unknown
Headache	☐ Yes ☐ No ☐ Unknown	Diarrhea	☐ Yes ☐ No ☐ Unknown
Other symptoms (provide details):			
Guillain-Barré syndrome/acute flaccid paralysis	☐ Yes ☐ No ☐ Unknown		
Microcephaly	☐ Yes ☐ No ☐ Unknown		

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LABORATORY INFORMATION

Date collected	Specimen type	Test	Result	Laboratory	Date reported

RISK FACTOR INFORMATION

Recent travel? ☐ Yes ☐ No ☐ Unknown Countries visited:	
Departure date from US: / /	Return date to US: / /

Is patient pregnant? ☐ Yes ☐ No ☐ Unknown	Due date: Weeks pregnant: as of /
Ultrasound performed? ☐ Yes (date: / / ; weeks pregnant) ☐ No ☐ Unknown	
Was ultrasound normal? ☐ Yes ☐ No, describe ☐ Unknown	

Known mosquito bites during travel or in 2 weeks prior to onset?	☐ Yes ☐ No ☐ Unknown
Unprotected sex with traveler from an affected area?	☐ Yes ☐ No ☐ Unknown
Patient received transplant or transfusion in 1 month prior to onset?	☐ Yes ☐ No ☐ Unknown
Patient donated blood in 2 weeks prior to onset?	☐ Yes ☐ No ☐ Unknown
Household or travel contacts with similar illness?	☐ Yes ☐ No ☐ Unknown

DISEASE AND VACCINATION HISTORY

Previously vaccinated against:	Yellow fever	☐ Yes (date: / /) ☐ No ☐ Unknown
	Japanese encephalitis	☐ Yes (date: / /) ☐ No ☐ Unknown
	Tickborne encephalitis	☐ Yes (date: / /) ☐ No ☐ Unknown

History of:	Dengue	☐ Yes (date: / /) ☐ No ☐ Unknown
	Chikungunya	☐ Yes (date: / /) ☐ No ☐ Unknown
	West Nile virus	☐ Yes (date: / /) ☐ No ☐ Unknown

REPORTING SOURCE

Name	Title
Affiliation	
Phone	FAX
Address (street, city, state, zip)	