Zika Virus Testing: Patient History

Form should be completed by primary provider. Patient to provide a copy to lab at time of specimen collection.

Form Completed by Name: ______________________________ **Phone:** _____________________ **Email:** _________________________________ **Patient FName:** ______________________________ **LName:** ______________________________ **Phone:** _____________________

Address: _________________________________ **DOB:** _____________________ **Age:** ________ **Sex:** ☐ M ☐ F

City: ____________ **State:** ____________ **Zip:** ____________

Provider FName: ______________________________ **LName:** ______________________________ **Facility:** _____________________

Phone: _____________________ **Email:** _____________________

Is the patient symptomatic: ☐ Y ☐ N

Date of symptom onset: ________________; **Symptoms (*mark all that apply*):**

☐ Rash If Yes, ☐ Maculopapular ☐ Patechial ☐ Purpuric ☐ Other: _______________________

☐ Fever; Recorded Temp:_______ ☐ Joint pain ☐ Conjunctivitis ☐ Myalgia ☐ Other: ____

Did the patient travel to an area with known Zika virus transmission: ☐ Y ☐ N

Country visited: _________________________________ Departure Date: ____________ Return Date: _________________________________

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History of living in a dengue-endemic area? : ☐ Y ☐ N If Yes, countries: ________________ Approximate Dates: ____________

Prior Diagnosis of Chikungunya: ☐ Y ☐ N Approximate Date: ____________

Prior Diagnosis of Dengue Fever: ☐ Y ☐ N Approximate Date: ____________

History of receiving yellow fever or Japanese encephalitis vaccine? : ☐ Y ☐ N Approximate Date: ____________

If no travel,
did the patient have unprotected sexual intercourse with a male who recently travelled to an area with known Zika virus transmission: ☐ Y ☐ N
Country visited by partner: _________________________Departure Date: ____________ Return Date: _________________________________

Did the sexual partner have symptoms consistent with Zika virus: ☐ Y ☐ N

Was the sexual partner tested for Zika virus: ☐ Y ☐ N

Is the patient pregnant? ☐ Yes ☐ No

If Yes,

a. Approximate gestational age when she traveled ____(week)
b. If applicable, approximate gestational age at symptom onset ____(week)
c. Gestational age at present ____(week)
d. Date of last ultrasound:_____________________ If, not performed, date scheduled:_____________________
e. Ultrasound findings: ☐ Normal ☐ Brain Calcification ☐ Microcephaly ☐ IUGR ☐ Other: ___________________

Additional tests ordered (and results if available) for other etiologies: ____
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Additional Comments:
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