

FLORIDA CONFIDENTIAL ZIKA VIRUS CASE REPORT FORM

(To be completed for all laboratory suspect, probable, and confirmed cases)

IDENTIFYING DATA:

Merlin #: _____ Interviewer's Name: _____ Date: _____

First Name: _____ Last Name: _____

Street Address: _____ City: _____

State: _____ Zip _____ County: _____ Phone: _____

Gender: Female Male DOB: _____ Preferred Language: _____

Race: White Black Asian/Pacific Islander American Indian/Alaskan Native Other: _____

Ethnicity: Hispanic Non-Hispanic Is the patient homeless? Yes No

Is the patient currently **pregnant**? Yes No

CLINICAL INFORMATION:

Asymptomatic

Cardinal Symptoms:

Fever onset: _____

Conjunctivitis onset: _____

Rash onset: _____ Was it itchy? Yes No

Arthralgia onset: _____

Other Symptoms:

Fatigue onset: _____

Myalgia onset: _____

Tingling/pins and needles onset: _____

Headache onset: _____

Retro-orbital pain onset: _____

Weakness onset: _____

Other: _____

Did your illness resolve? Yes No

If yes, date: _____

Did any other household member experience a febrile illness within the month prior to or the month after onset (**symptomatic only**)? Yes No

If yes, date onset: _____

EXPOSURE PERIOD NOTE:

Symptomatic: 2 weeks prior to onset

Asymptomatic: 2 years prior to diagnosis

Blood donors: 6 months prior to donation

RISK FACTOR INFORMATION:

1. What is your occupation? _____

2. Do you spend more than 4 hours outside at your occupation? Yes No

3. Do you smoke? Yes No If yes, do they smoke outdoors? Yes No

4. Do you have any underlying medical conditions? Yes No

If yes, list: _____

5. Do you have any pre-existing joint disorders such as arthritis? Yes No

If yes, list: _____

6. Does your current residence have screened windows? Yes No

7. Do you use any prevention measures to avoid mosquito bites (drain and cover)? Yes No

If yes list: _____

If yes, do you use repellent when outdoors? Yes No

If yes, does it contain DEET? Yes No

8. Do you recall being bitten by mosquitoes during the **exposure period**? Yes No

If yes, dates and places: _____

9. Do you spend extended time outdoors during the **exposure period**? Yes No

10. Have you ever been previously diagnosed with an arbovirus infection? Yes No

If yes, date: _____

If yes, country of origin: _____

If yes, arbovirus: _____

TRAVEL INFORMATION:

11. Have you traveled outside your county of residence during the **exposure period**? Yes No
If yes, where? _____
If yes, dates of travel: _____
If yes, provide a reason for travel: _____
12. Has anyone in your household, a close personal contact, or a co-worker traveled to an area experiencing Zika virus activity in the month prior to onset of symptoms (**answer for symptomatic only**)?
If yes, date returned: _____
If yes, country visited: _____
13. Have you had sexual relations with a partner who traveled to or lived in an endemic country or an area experiencing Zika virus activity? Yes No
-

For locally acquired cases and non-Florida residents only:

Symptomatic: enter addresses where the patient spent time during the exposure period.

Asymptomatic/Blood donor: enter home, work, and other relevant addresses.

Type	Location Name	Street Address	City, State, and Zip

BLOOD DONATION INFORMATION:

14. Have you received a transplant or blood products in the month prior to onset? Yes No
a. If yes, date: _____
b. If yes, location: _____
15. Have you donated blood products or an organ in the one month prior to onset? Yes No
a. If yes, date: _____
b. If yes, location: _____
-

PREGNANT WOMEN ONLY:

16. What is your due date? _____
17. When was your last menstrual period? _____
18. Are you currently breastfeeding or planning to breastfeed? Yes No
19. Have you ever had a previous pregnancy with diagnosed microcephaly or other abnormalities? Yes No
If yes, list: _____
20. Are you receiving prenatal care? Yes No
If no, would the patient wish to be linked to prenatal care? Yes No
21. Have you ever received information about Healthy Start? Yes No
If no, would you like to be referred to Healthy Start services? Yes No
22. Physician-OB/GYN: _____ Phone # _____
23. Birth facility: _____