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| 1. **Interview Information**
 |
| Date of interview: MM / DD / YYYY **Interviewer:** Interviewer Name (Last, First): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State/Local Health Department: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Business Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_County: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Contact:**Who is providing information for this form? Contact Other, specify person (Last, First): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Reason contact unable to provide information: Contact is a minor Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Contact primary language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Was this form administered via a translator? □ Yes □ No |

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| 1. **Ebola Case Information (Case associated with Contact)**
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| At the time of this report, is the patient? □ Confirmed □ Probable □ UnknownDate of illness onset of patient: MM / DD / YYYY Notes: |

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| 1. **Contact Information**
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| Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Home Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Apt. # \_\_\_\_\_\_\_\_\_\_\_\_\_City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ County: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time at current residence: \_\_\_\_\_\_\_\_\_\_\_Previous address *(if less than 1 month at current residence):*Home Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Apt. # \_\_\_\_\_\_\_\_\_\_\_\_\_City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_County: \_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Country:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Other Phone number or contact information:: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| 1. **Contact Demographics**
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| **Date of birth**: MM  **/** DD  **/** YYYY **Age:** **Sex:**  Male Female What is your occupation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ***If HCW that provided care to Ebola patient or worker (in any capacity including janitorial, lab, medical waste, food services, etc.)at a healthcare facility that treated Ebola patient, skip to Section VII now***Place of work and address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Do you have any pets in your household?:**  Yes Give species and number\_\_\_\_\_\_\_\_\_\_\_\_\_ No NOTES: |

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| 1. **Exposure History** \*Question assesses LOW exposure; †Question assesses HIGH exposure; ‡Question assesses casual contact or NO KNOWN exposure; Note: direct contact requires contact with skin and or mucous membranes.
 |
| 1) What is your relationship to the patient?   Partner/spouse  Family member  Co-worker  Friend/acquaintance   Classmate  Visited same healthcare facility/care area as Ebola patient   Neighbor/community member  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2) \*Do you live in the same house as the patient?  Yes  No 3) Did you have any contact with the patient while he/she was ill?  Yes  No  Unsure  If yes, please describe and provide dates of first and last contact (include description of any PPE used):  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_4) †Did you have any contact with blood or body fluids from the patient while he/she was ill (including  contaminated objects or surfaces such as bedding or clothing)? Yes No *(skip to Q5)*  Unsure If yes, what body fluids were you in contact with? (check all that apply)  Blood  Feces  Vomit  Urine  Sweat  Tears  Respiratory secretions  Semen  Vaginal fluids   Other, specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Last date of contact: MM / DD / YYYY **(Skip to Section VI)**5) \*Were you within approximately 3 feet of the patient or within his/her room or care area for a prolonged  period of time (at least one hour)? Yes No Unsure If yes, date of last contact: MM / DD / YYYY 6) \*Did you have any direct contact with the patient (e.g. shaking hands) no matter how brief?  Yes Date of last contact: MM / DD / YYYY **(Skip to Section VI)**  No Unsure 7) ‡Did you have any casual contact with the patient (meaning a brief interaction, such as walking by him/her  or being in the same room for a very short period of time) in which you did not directly touch him/her?  Yes No Unsure  If yes, date of last contact: MM / DD / YYYY  |

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| 1. **Activities During Period Of Exposure**
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| **Did you participate in any of the following activities with the patient while he/she was ill?****Caregiving**Did you take care of the patient when he/she was sick (e.g. bathe, feed, help to bathroom)? Yes No UnsureDid you do house cleaning or provide indirect care for the patient (e.g. wash clothes or bedding, wash dishes)? Yes No Unsure **Sharing Meals**Did you eat meals with the patient? Yes No UnsureDid you share utensils or a cup with the patient? Yes No Unsure**Other close contact**Did you use the same bathroom as the patient? Yes No UnsureDid you sleep in the same room as the patient? Yes No UnsureDid you sleep in the same bed as the patient? Yes No UnsureDid you hug the patient? Yes No UnsureDid you kiss the patient? Yes No Unsure**Transportation**Did you share any transport with the patient (car, bus, plane, taxi, etc.)? Yes No UnsureIf yes, give for *all* shared transport: Conveyance \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dates of travel: \_\_\_\_\_\_\_\_ Name of airline and flight number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Origin: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Destination: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Any transit points: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| **Notes:** |

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|  **Health Care Worker (HCW) Survey** |
| 1. **Healthcare Facility Information**
 |
| Facility Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Facility Type\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Campus/Building \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_County: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Job title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Where is your primary site of work in the facility [e.g., specific ward(s), floor(s), department(s)]?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| 1. **HCW Exposure History***\*Question assesses LOW exposure; †Question assesses HIGH exposure; ‡Question assesses casual contact (NO KNOWN exposure)*
 |
| 1. Did you have any contact with the Ebola patient while he/she was ill? Yes No Unsure

 If yes, please describe and provide dates of first and last contact: 1. *\**Were you within approximately 3 feet of the patient or within his/her room or care area for a prolonged

 period of time? (*This includes while wearing PPE*) Yes No ***(skip to Q3)*** Unsure **If yes,** what PPE was worn on these occasions? *Check all that apply*  Gloves Gown (impermeable) Eye protection (goggles or face shield) Facemask  N95 or other respirator Body suit None  Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If any PPE was worn, was donning of PPE witnessed? Yes Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No Unsure  If any PPE was worn, was patient care witnessed? Yes Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No Unsure  If any PPE was worn, was doffing of PPE witnessed? Yes Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No Unsure  Last date(s) of exposure: MM / DD / YYYY  **(*Skip to Q4)*** |

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| 1. **HCW Exposure History continued** *\*Question indicates LOW exposure; †Question indicates HIGH exposure; ‡Question indicates casual contact (NO KNOWN exposure)*
 |
| 1. ‡Did you have any casual contact with the patient (meaning a brief interaction, such as walking by him/her or being in the same room for a very short period of time) in which you did not directly touch him/her? Yes No Unsure

If yes, date of last contact: MM / DD / YYYY 1. *\**Did you have any direct contact\*\* with the patient (e.g. shaking hands) no matter how brief?

 (*This includes while wearing PPE*) Yes No Unsure  **If yes,** what PPE was worn on these occasions? *Check all that apply*  Gloves Gown (impermeable) Eye protection (goggles or face shield) Facemask  N95 or other respirator Body suit None  Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If any PPE was worn, was donning of PPE witnessed? Yes Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No Unsure  If any PPE was worn, was patient care witnessed? Yes Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No Unsure  If any PPE was worn, was doffing of PPE witnessed? Yes Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No Unsure  Last date(s) of contact: MM / DD / YYYY  |

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| 1. **HCW Exposure History cont’d**
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| 5) †Did you have any direct contact with blood or body fluids from the patient while he/she was ill (including contaminated objects or surfaces such as bedding or clothing)? (This includes while wearing PPE)  Yes No UnsureIf yes,  What body fluids were you in contact with? (check all that apply)  Blood  Feces  Vomit  Urine  Sweat  Tears  Respiratory secretions (e.g. sputum, nasal mucus)  Saliva   Semen or vaginal fluids  Other, specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  What PPE was worn on these occasions? Check all that apply   Gloves Gown (impermeable) Eye protection (goggles or face shield) Facemask  N95 or other respirator  Body suit None   Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If any PPE was worn, was donning of PPE witnessed?  Yes Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   No  Unsure  If any PPE was worn, was patient care witnessed?  Yes Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   No  Unsure  If any PPE was worn, was doffing of PPE witnessed?  Yes Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   No  Unsure   Last date(s) of blood/body fluid exposure: MM / DD / YYYY  |

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| 1. **HCW Exposure History****cont’d**
 |
| **NOTES:** Please describe any lapses in proper infection control practices that may have occurred during any of these contacts and describe what happened (e.g., inappropriate/ ineffective disinfection; defective gloves, gowns, mask). Include hospital location (outpatient care, acute inpatient, ED, ICU, long-term care, clinical lab, dialysis center, etc.), response to breach, and duration of each occurrence:   |

**Follow-up Actions:**

[ ]  No further follow-up required. Does not meet criteria for high or low exposure or exposure was >21 days.

[ ]  Observed Fever Monitoring Recommended

 [ ]  High risk exposure [ ]  Low risk exposure

 Last exposure date: MM / DD / YYYY Last day of monitoring: MM / DD / YYYY

 Who will conduct the follow-up for fever monitoring?

 Name/Affiliation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Phone Number and Contact Information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Self- Monitoring Recommended (for No Known Exposure only)

 Last exposure date: MM / DD / YYYY Last day of monitoring: MM / DD / YYYY

 Who will conduct the follow-up for fever monitoring?

 Name/Affiliation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Phone Number and Contact Information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Respondent has had a fever or severe headache, muscle pain, diarrhea, vomiting, abdominal pain,

 unexplained hemorrhage (bleeding or bruising) since having contact with the patient

 Temperature: \_\_\_\_\_\_\_\_°F

Fever onset date: MM / DD / YYYY

Symptoms: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Where will the patient be evaluated for fever? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| 1. **Contact Symptom Follow-Up Diary**
 |
| **1 day after last exposure**MM / DD / YYYY | **2 days after last exposure**MM / DD / YYY  | **3 days after last exposure**MM / DD / YYYY | **4 days after last exposure**MM / DD / YYYY  | **5 days after last exposure**MM / DD / YYYY |
| □ No symptoms□ Fever \_\_\_\_\_\_\_\_○F□ Chills □ Weakness □ Headache □ Muscle Aches □ Abdominal Pain□ Diarrhea \_\_\_\_times/day□ Vomiting□ Unexplained hemorrhage□ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | □ No symptoms□ Fever \_\_\_\_\_\_\_\_○F□ Chills □ Weakness □ Headache □ Muscle Aches □ Abdominal Pain□ Diarrhea \_\_\_\_times/day□ Vomiting□ Unexplained hemorrhage□ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | □ No symptoms□ Fever \_\_\_\_\_\_\_\_○F□ Chills □ Weakness □ Headache □ Muscle Aches □ Abdominal Pain□ Diarrhea \_\_\_\_times/day□ Vomiting□ Unexplained hemorrhage□ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | □ No symptoms□ Fever \_\_\_\_\_\_\_\_○F□ Chills □ Weakness □ Headache □ Muscle Aches □ Abdominal Pain□ Diarrhea \_\_\_\_times/day□ Vomiting□ Unexplained hemorrhage□ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | □ No symptoms□ Fever \_\_\_\_\_\_\_\_○F□ Chills □ Weakness □ Headache □ Muscle Aches □ Abdominal Pain□ Diarrhea \_\_\_\_times/day□ Vomiting□ Unexplained hemorrhage□ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **6 days after last exposure**MM / DD / YYYY | **7 days after last exposure**MM / DD / YYYY | **8 days after last exposure**MM / DD / YYYY | **9 days after last exposure**MM / DD / YYYY | **10 days after last exposure**MM / DD / YYYY |
| □ No symptoms□ Fever \_\_\_\_\_\_\_\_○F□ Chills □ Weakness □ Headache □ Muscle Aches □ Abdominal Pain□ Diarrhea \_\_\_\_times/day□ Vomiting□ Unexplained hemorrhage□ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | □ No symptoms□ Fever \_\_\_\_\_\_\_\_○F□ Chills □ Weakness □ Headache □ Muscle Aches □ Abdominal Pain□ Diarrhea \_\_\_\_times/day□ Vomiting□ Unexplained hemorrhage□ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | □ No symptoms□ Fever \_\_\_\_\_\_\_\_○F□ Chills □ Weakness □ Headache □ Muscle Aches □ Abdominal Pain□ Diarrhea \_\_\_\_times/day□ Vomiting□ Unexplained hemorrhage□ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | □ No symptoms□ Fever \_\_\_\_\_\_\_\_○F□ Chills □ Weakness □ Headache □ Muscle Aches □ Abdominal Pain□ Diarrhea \_\_\_\_times/day□ Vomiting□ Unexplained hemorrhage□ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | □ No symptoms□ Fever \_\_\_\_\_\_\_\_○F□ Chills □ Weakness □ Headache □ Muscle Aches □ Abdominal Pain□ Diarrhea \_\_\_\_times/day□ Vomiting□ Unexplained hemorrhage□ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **11 days after last exposure**MM / DD / YYYY | **12 days after last exposure**MM / DD / YYYY | **13 days after last exposure**MM / DD / YYYY | **14 days after last exposure**MM / DD / YYYY | **15 days after last exposure**MM / DD / YYYY |
| □ No symptoms□ Fever \_\_\_\_\_\_\_\_○F□ Chills □ Weakness □ Headache □ Muscle Aches □ Abdominal Pain□ Diarrhea \_\_\_\_times/day□ Vomiting□ Unexplained hemorrhage□ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | □ No symptoms□ Fever \_\_\_\_\_\_\_\_○F□ Chills □ Weakness □ Headache □ Muscle Aches □ Abdominal Pain□ Diarrhea \_\_\_\_times/day□ Vomiting□ Unexplained hemorrhage□ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | □ No symptoms□ Fever \_\_\_\_\_\_\_\_○F□ Chills □ Weakness □ Headache □ Muscle Aches □ Abdominal Pain□ Diarrhea \_\_\_\_times/day□ Vomiting□ Unexplained hemorrhage□ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | □ No symptoms□ Fever \_\_\_\_\_\_\_\_○F□ Chills □ Weakness □ Headache □ Muscle Aches □ Abdominal Pain□ Diarrhea \_\_\_\_times/day□ Vomiting□ Unexplained hemorrhage□ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | □ No symptoms□ Fever \_\_\_\_\_\_\_\_○F□ Chills □ Weakness □ Headache □ Muscle Aches □ Abdominal Pain□ Diarrhea \_\_\_\_times/day□ Vomiting□ Unexplained hemorrhage□ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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| **16 days after last exposure**MM / DD / YYYY | **17 days after last exposure**MM / DD / YYYY | **18 days after last exposure**MM / DD / YYYY | **19 days after last exposure**MM / DD / YYYY | **20 days after last exposure**MM / DD / YYYY |
| □ No symptoms□ Fever \_\_\_\_\_\_\_\_○F□ Chills □ Weakness □ Headache □ Muscle Aches □ Abdominal Pain□ Diarrhea \_\_\_\_times/day□ Vomiting□ Unexplained hemorrhage□ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | □ No symptoms□ Fever \_\_\_\_\_\_\_\_○F□ Chills □ Weakness □ Headache □ Muscle Aches □ Abdominal Pain□ Diarrhea \_\_\_\_times/day□ Vomiting□ Unexplained hemorrhage□ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | □ No symptoms□ Fever \_\_\_\_\_\_\_\_○F□ Chills □ Weakness □ Headache □ Muscle Aches □ Abdominal Pain□ Diarrhea \_\_\_\_times/day□ Vomiting□ Unexplained hemorrhage□ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | □ No symptoms□ Fever \_\_\_\_\_\_\_\_○F□ Chills □ Weakness □ Headache □ Muscle Aches □ Abdominal Pain□ Diarrhea \_\_\_\_times/day□ Vomiting□ Unexplained hemorrhage□ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | □ No symptoms□ Fever \_\_\_\_\_\_\_\_○F□ Chills □ Weakness □ Headache □ Muscle Aches □ Abdominal Pain□ Diarrhea \_\_\_\_times/day□ Vomiting□ Unexplained hemorrhage□ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **21 days after last exposure**MM / DD / YYYY |
| □ No symptoms□ Fever \_\_\_\_\_\_\_\_○F□ Chills □ Weakness □ Headache □ Muscle Aches □ Abdominal Pain□ Diarrhea \_\_\_\_times/day□ Vomiting□ Unexplained hemorrhage□ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**NOTES:** |

**NOTES:**