Fermilab

Influenza Screening

Medical Office/ESH

Date _____ Time Called _____ ☐ AM ☐ PM Location _____

Name: _____ ID# _____ Div/Sec _____

Phone # can be reached _____ Supervisor notified? ☐ Yes ☐ No

Date of onset of symptoms _____

Date of first presentation to health care system _____

				Comment
Fever > 100 degrees F (38 degrees C)	☐ Yes	☐ No	☐ Unk	
History of fever (temp not measured)	☐ Yes	☐ No	☐ Unk	
Sore throat	☐ Yes	☐ No	☐ Unk	
Runny nose	☐ Yes	☐ No	☐ Unk	
Sneezing	☐ Yes	☐ No	☐ Unk	
Dry cough	☐ Yes	☐ No	☐ Unk	
Productive cough	☐ Yes	☐ No	☐ Unk	
Shortness of breath	☐ Yes	☐ No	☐ Unk	
Conjunctivitis	☐ Yes	☐ No	☐ Unk	
Diarrhea	☐ Yes	☐ No	☐ Unk	
Nausea	☐ Yes	☐ No	☐ Unk	
Vomiting	☐ Yes	☐ No	☐ Unk	
Headache	☐ Yes	☐ No	☐ Unk	
Seizures	☐ Yes	☐ No	☐ Unk	
Altered consciousness	☐ Yes	☐ No	☐ Unk	
Muscle pain	☐ Yes	☐ No	☐ Unk	
Joint pain	☐ Yes	☐ No	☐ Unk	
Nose bleed	☐ Yes	☐ No	☐ Unk	
Family member	☐ Yes	☐ No	☐ Unk	
Other (specify)	☐ Yes	☐ No	☐ Unk	

Do you have any pre-existing conditions? ☐ Yes ☐ No ☐ Unk

				Comments
Cancer	☐ Yes	☐ No	☐ Unk	
Diabetes	☐ Yes	☐ No	☐ Unk	
HIV/other immune deficiency	☐ Yes	☐ No	☐ Unk	
Heart disease	☐ Yes	☐ No	☐ Unk	
Seizure disorder	☐ Yes	☐ No	☐ Unk	
Lung disease	☐ Yes	☐ No	☐ Unk	
Pregnancy	☐ Yes	☐ No	☐ Unk	
Malnutrition	☐ Yes	☐ No	☐ Unk	
Other (specify)	☐ Yes	☐ No	☐ Unk	

Exposure/ Possible Exposure

Did you recently travel outside of the US? ☐ Yes ☐ No If so, where:

In the 7 days prior to onset of symptoms the person was in an area where cases of Swine influenza A(H1N1) virus had been identified. ☐ Yes ☐ No ☐ Unk

if YES, name area

Exposure (contact within touching/speaking distance) in the 7 days before onset of illness to confirmed or probable Swine Influenza A(H1N1) case ☐ Yes ☐ No ☐ Unk

Have you had any testing for influenza A virus? ☐ Yes ☐ No ☐ Unk

Advice

Medical person's signature Date