SEVERE ACUTE RESPIRATORY SYNDROME SCREENING FORM

17 March 2003

Current Date: _____/_____/_____ Medical Record Number: _____

Last Name: _____First Name: _____MI: _____

Street Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone Number: (____) _____ Occupation: _____

Work Address: _____ City: _____ State: _____ Zip Code: _____

Age: ___Date of Birth: ____/____/____ Sex: ____ Date Symptoms Started: _____/____/_____

In the past 2 weeks, have you traveled to a foreign country(s)? If yes, identify city(s)/country(s)?

_____

In the past 10 days have you returned from travel to Hong Kong; Guangdong Province in People's Republic of China; Hanoi, Vietnam; or Singapore or have you had close contact (lived with, cared for, had direct contact with respiratory secretions and body fluids) with any person who had recently traveled to those countries who was ill?
If yes, identify city(s)/country(s), person, nature of illness, nature of contact?

_____

In the past 10 days, have you traveled to other USA cities? If yes, identify city(s):

_____

Since the onset of symptoms have you traveled by air, bus, train or other public transportation? If yes, provide short history._____

_____

Over the past 7 days, have you had any of the following symptoms or ailments? (Check all that apply).

Symptoms	Yes	Symptoms	Yes
Fever		Trouble breathing	
Upset stomach (nausea)		Sweating excessively	
Headache		Pain or tightness in the chest	
Dry cough		Very tired	
Sore muscles		Pain in the stomach	
Sore throat		Diarrhea	