TEXAS Department of State Health Services

Zoonosis Control Branch

Chikungunya, Dengue, and Zika Testing Supplemental Information

PLEASE PRINT CLEARLY AND COMPLETE ALL SECTIONS. This information is REQUIRED prior to testing. This form should be included with the specimen(s) and DSHS laboratory submission form(s).

Submitter or Reporting Jurisdiction

Person completing form:_____ Phone number:_____

City:_____ County:_____

Local or Regional Health Department Representative Contacted **PRIOR** to submitting specimen:

Name: _____ Agency: _____

Patient's Demographic Information

Patient Name: Last:_____ First:_____

Sex: ☐ Male ☐ Female

Age: _____ ☐ Years ☐ Months

County of residence: _____

Is Patient Pregnant: ☐ Yes ☐ No

If Yes, gestational week at illness onset or during travel/residence in affected area: _____

Did patient travel outside of residence County in 2 weeks prior to illness onset? ☐ Yes ☐ No ☐ Unknown

Patient's Travel History

See maps/lists of affected areas: **www.cdc.gov/zika** **www.cdc.gov/dengue** **www.cdc.gov/chikungunya**

Dates of travel: _____/_____/_____ (MM/DD/YYYY) to _____/_____/_____ (MM/DD/YYYY)

County(s), State(s), or Country(s) visited:_____

Male Sexual Partner's Travel History

Did the patient's male sexual partner travel to an area of ongoing Zika virus transmission and develop a clinical illness consistent with Zika virus disease during travel or within 2 weeks of his return?

☐ Yes ☐ No ☐ Unknown ☐ Not applicable

Dates of travel: _____/_____/_____ (MM/DD/YYYY) to _____/_____/_____ (MM/DD/YYYY)

County(s), State(s), or Country(s) visited:_____

Patient's Vaccination History

Has the patient previously been vaccinated for any of the following:

Yellow Fever ☐ Yes ☐ No ☐ Unknown If **Yes**, year of vaccination:_____

Japanese Encephalitis ☐ Yes ☐ No ☐ Unknown If **Yes**, year of vaccination:_____

Tickborne Encephalitis ☐ Yes ☐ No ☐ Unknown If **Yes**, year of vaccination:_____

Patient's Illness Information (Please check all that apply)

Illness onset date:_____ ☐ Not applicable - patient not ill

Fever ☐ Yes ☐ No ☐ Unknown

If **Yes**: ☐ Subjective fever ☐ Measured fever (Maximum measured temperature: _____)

Rash ☐ Yes ☐ No ☐ Unknown

If **Yes**:

Type: ☐ Maculopapular ☐ Petechial ☐ Purpuric ☐ Other

Pruritic: ☐ Yes ☐ No

Distribution:_____

Additional clinical symptoms: ☐ Not applicable - patient not ill

☐ Arthralgia ☐ Headache ☐ Nausea ☐ Other_____

☐ Conjunctivitis ☐ Myalgia ☐ Vomiting _____