Print Form

Avian Influenza Exposure Symptom Questionnaire

Date of interview (mm/dd/yy)_____ **Name of interviewer:** _____

Name: (Last)_____ **(First)** _____

Address (# Street Name): _____ **City/State/ZIP:**_____

County of Residence:_____ **Primary Language Spoken** _____

Home Phone:_____ **Work/cell phone:** _____

Age (Years): _____ **DOB (mm/dd/yy)**: _____ **Gender:** ☐ **M** ☐ **F**

<u>Vaccination Information</u>:
Did you receive an influenza vaccination this year?
☐ Yes (approximate date mm/dd/yy_____) What type? ☐ Flu shot ☐ FluMist® ☐ No

<u>Work Information</u>:
Occupation: _____

Employer: Poultry Company _____**Private contractor** _____
State/Fed Agency_____

Type of work (check all that apply):

☐ Care of live poultry
☐ Transportation of live poultry
☐ Cleaning of poultry houses, cages or trucks
☐ Obtaining blood samples of poultry
☐ Process poultry specimens in a lab
☐ Obtain cloacal or tracheal swabs
☐ Slaughter poultry (not depopulation)
☐ Poultry depopulation
☐ Composting dead poultry
☐ Disinfecting equipment
☐ Farm owner
☐ Other farm work

☐ Other _____

What is the most recent date you were performing any of the above activities (at any location)?

Date (mm/dd/yy)**:** _____ ☐ Still performing above duties

What is the most recent date you performed any of the above activities at a site where poultry were known to be infected with avian influenza?

Date (mm/dd/yy)**:** _____ ☐ Still performing above duties

While performing these activities (during the past two weeks), have you used personal protective equipment (PPE)?

☐ Yes, always ☐ Yes, most of the time ☐ Yes, sometimes ☐ Never

Name: (Last)_____ **(First)** _____

Exposure Date (mm/dd/yy): _____ **Exposure Location** _____ **Exposure #** _____

If you used PPE, which articles did you use? (Check all that apply)

☐ Protective clothing (such as disposable clothing)
☐ Fit-tested respirator (such as an N95 or higher mask)
☐ Disposable protective foot wear or washable boots
☐ Disposable gloves
☐ Eye Protection
☐ Other _____
☐ Hair bonnet

Health Assessment:

Since your first possible contact with avian influenza infected birds, have you developed any of the following symptoms?

Symptoms	Day 0 (Today's Date: _____)			Day 7 (Today's Date:_____)			Day 14 (Today's Date:_____)		
	Circle One	Date of Onset	Date Resolved	Circle One	Date of Onset	Date Resolved	Circle One	Date of Onset	Date Resolved
Fever	Yes No			Yes No			Yes No		
Measured Temp ≥ 100F	Yes No Temp°:			Yes No Temp°:			Yes No Temp°:		
Cough	Yes No			Yes No			Yes No		
Sore Throat	Yes No			Yes No			Yes No		
Runny Nose	Yes No			Yes No			Yes No		
Body Aches *	Yes No			Yes No			Yes No		
Red or Watery Eyes	Yes No			Yes No			Yes No		
Diarrhea	Yes No			Yes No			Yes No		
Headache	Yes No			Yes No			Yes No		
Drowsiness	Yes No			Yes No			Yes No		
Other: _____	Yes No			Yes No			Yes No		

*** Symptom by itself does not indicate referral to local health department for follow-up**

Additional documentation may be on an attached form.

Did you seek medical care for your illness? ☐ No ☐ Yes

If yes, name of provider: _____**Address:** _____**Phone Number:** _____

Were you hospitalized? ☐ No ☐ Yes If yes, Name of Hospital _____ Dates admitted _____

Antiviral Information:

Have you taken any antiviral medication? [Amantadine(Symmetrel), Rimantadine (Flumadine), Oseltamivir (Tamiflu)]

☐ Yes Name of antiviral: _____ First dose _____ Last dose _____ ☐ No

Have any of your family members or other close contacts developed any of the above symptoms? ☐ No ☐ Yes **If yes, who?**

Name	Age (Yrs.)	Relationship	Contact #