



Zika Virus Testing for Pregnant Women

Date ___/___/___

DEMOGRAPHICS

Name (Last, First): _____ DOB: ___/___/___

Phone: _____

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

Ethnicity: Hispanic Non-Hispanic
Race: White Black Other Asian / Pacific Islander
 American Indian / Alaskan Unknown / Not specified

PREGNANCY STATUS

Due date: ___/___/___

Week of Pregnancy: _____

Physician (Name): _____

Physician (Address): _____

SYMPTOMS

Have you had any of the following symptoms in the last 14 days? Yes No Unknown

Check all that apply: None Fever Rash Joint Pain Conjunctivitis (reddened eyes)
 Other _____

TRAVEL HISTORY

Did you travel outside of the continental U.S. in the last 14 days? Yes No Unknown

If yes, Country/Countries _____

Dates of travel ___/___/___ to ___/___/___ Returned to Florida (date) ___/___/___

Did you travel outside of the continental U.S. in the last 6 months? Yes No Unknown

If yes, Country/Countries _____

Dates of travel ___/___/___ to ___/___/___ Returned to Florida (date) ___/___/___

Additional Comments: _____