# ZIKA VIRUS EXPOSURE RISK QUESTIONNAIRE

New Leaders in Fertility and Endocrinology - 4400 Bayou Boulevard, #36 Pensacola, FL P:850-857-3733 F:850-857-0670

| | | |
|---|---|---|
| Print Female Patient Name | Date of Birth | Date completed |
| Print Male Patient Name | Date of Birth | Date completed |

| Female | Male | Please circle "yes" or "no" for each question below: |
|---|---|---|
| Yes No | Yes No | Have you traveled to, or lived in an area with known ZIKA virus in the last 12 months? (If unsure, consult the CDC website list of locations at risk: https://wwwnc.cdc.gov/travel/page/zika-travel-information ) |
| Yes No | Yes No | If you have traveled to or lived in an area with known ZIKA virus in the past 12 months, have you experienced any the following ZIKA virus symptoms: mild illness with fever, rash, joint pain or red eyes? |
| Yes No | Yes No | In the last 12 months, have you had sex without a condom (vaginal, anal or oral) with a person who has traveled to, or lived in an area with known ZIKA virus, or who has had ZIKA virus symptoms? |
| Yes No | Yes No | Do you have plans presently to travel to an area with known ZIKA virus? If yes, when & where will you travel? _____ |
| Yes No | Yes No | Have you ever tested positive for the ZIKA virus? |

**Patient Resources and Advice:**

Travelers to South Florida: https://www.cdc.gov/zika/intheus/florida-update.html
Personal prevention: https://www.cdc.gov/zika/prevention/prevent-mosquito-bites.html
Prevention of Sexual Transmission: https://www.cdc.gov/zika/prevention/sexual-transmission-prevention.html

## Patient Acknowledgment

By providing my signature below, I hereby acknowledge the known risks to pregnancy of Zika virus infection, the uncertainties regarding current CDC guidelines, and limitations of preventive measures (avoiding mosquito bites) and limitations of blood testing (false positive, false negative testing).

Further, I understand the need and accept the personal responsibility to provide updated information to this medical practice, if my travel or exposure affects my risk for contracting Zika virus infection, and to postpone conception, if necessary for possible Zika virus exposure.

Female: _____ Date: _____

Male: _____ Date: _____

NewLIFE Employee Witness: _____ Date: _____

(If any "yes" above, deliver this document to clinical healthcare provider for additional notes)

Additional Notes/Clarification by Provider: _____

_____

_____

Provider: _____ Date: _____