

Evaluating a Person Under Investigation (PUI)
for Ebola Virus Disease (EVD) Form

Patient Interview Date: _____

Time: ____:____ AM PM

Submitter Name: _____

Submitter Title: _____

Phone Number: (____) _____ Ext. _____

Facility Name: _____

Facility Address: _____

Patient Information

Last Name: _____ First Name: _____ Middle Name: _____

DOB: _____ Age: _____ years months Sex: female male other

Address: _____

City: _____ State: _____ Zip Code: _____

Country of Residence: _____ Occupation: _____

E-mail: _____

Cell Phone: _____ Home Phone: _____

Name of alternate contact person: _____

Phone number for alternate contact person: _____

Date of initial symptom onset: _____

Which of the following signs and symptoms of Ebola does the patient have:

- | | |
|--|--|
| <input type="checkbox"/> fever (subjective? Yes No ____°F/ ____°C) | <input type="checkbox"/> diarrhea |
| <input type="checkbox"/> headache | <input type="checkbox"/> vomiting |
| <input type="checkbox"/> muscle pain | <input type="checkbox"/> abdominal pain |
| <input type="checkbox"/> fatigue | <input type="checkbox"/> unexplained hemorrhage (bleeding, bruising) |
| <input type="checkbox"/> weakness | |
| <input type="checkbox"/> other symptoms- please describe: | |

Travel History

Please list the country(ies)* that the patient visited in the 21 days before the onset of symptoms.

*Please limit to countries currently experiencing an EVD outbreak (<https://www.cdc.gov/vhf/ebola/outbreaks/index-2018.html>) or countries where there have been confirmed cases (<https://wwwnc.cdc.gov/travel/diseases/ebola>)

Name of 1st country visited	
Cities/Towns visited	
Date arrived to country	
Date left country	
Name of 2nd country visited	
Cities/Towns Visited	
Date arrived to country	
Date left country	
Name of 3rd country visited	
Cities/Towns Visited	
Date arrived to country	
Date left country	
Name of 4th country visited	
Cities/Towns Visited	
Date arrived to country	
Date left country	

Flight Information: List all travel in the 21 days before the onset of symptoms:

Flight/Bus	Date	Airline/Bus Company	From City/Country	To City/Country
Leg 1				
Leg 2				
Leg 3				
Leg 4				
Leg 5				
Leg 6				

Time arrived in the US: _____ Arrival Airport in US: _____

Additional travel details:

Any symptoms during travel? Yes No Unknown

While on aircraft/at airport? Yes No Unknown

Location and symptom details: _____

Did the patient have any travel companions who are also currently in the US? Yes No Unknown

If yes, please provide the details below:

Name	Age (if less than 18 years old)	Relationship to Patient	Phone Number

Check the activities that the patient conducted while in the country(ies) listed above:

- Provided healthcare to sick person
Interacted with a sick person who was in a country experiencing an EVD outbreak or country where there has been confirmed cases (please describe details below)
Handled items that may have come in contact with a sick person's blood or body fluids (urine, saliva, sweat, feces, vomit, breast milk, and semen)
Had contact with blood or body fluids (urine, saliva, sweat, feces, vomit, breast milk, and semen) in a laboratory setting
Had direct contact with a person who has or previously had EVD (including sexual contact)
Participated in dead body preparation or funeral
Visited caves
Came into contact with bats or non-human primates (such as apes or monkeys) or raw meat (bushmeat) prepared from these animals in a country experiencing an EVD outbreak or country where there has been confirmed cases

Please provide more details (such as if personal protective equipment was worn), including other activities in the countries visited:

Three horizontal lines for providing details.

Since coming to the US, was the patient seen by another medical provider prior to this current visit:

- Yes No Unknown

Details/Location/Date: _____

Medical History:

List medications taken while on travel (include malaria chemoprophylaxis):

Horizontal line for medication list.

Were antimalarials taken? Yes No Unknown

If yes, were any doses missed? Yes No Unknown

Pre-travel yellow fever vaccination: Yes No Unknown

Pre-travel typhoid vaccination: Yes No Unknown

Any illnesses while abroad and treatments: _____

Significant past medical history (e.g., illnesses/conditions): _____

General Appearance: Healthy Discomfort Distressed Toxic

Were recent malarial tests performed? (In US or in countries listed above) Yes No Unknown

Thick/thin smear for malaria: Yes No Pending Result: _____

Rapid test for malaria (type if known): Yes No Pending Result: _____

Infection Control

Mode of transportation used to bring patient to hospital/clinic: Privately owned vehicle Ambulance
 Medevac Aircraft Ride share service (e.g. Uber, Lyft) Metrorail Metro bus Other: _____

Additional Important Information: