State of California—Health and Human Services Agency

Department of Health Services

California Department of Health Services

SANDRA SHEWRY
Director

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Governor

SEVERE ACUTE RESPIRATORY SYNDROME (SARS)
PATIENT SCREENING FORM
March 2006

Current Date_____/_____/_____ Medical Record Number:_____

Last Name:_____ First Name:_____ MI:_____

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

Home Phone Number: ( )_____ Occupation:_____

Work Address:_____ City:_____ State:_____ Zip Code:_____

Age:_____ Date of Birth:_____ Sex:_____ Date Symptoms Started:_____

1. In the past 10 days, have you returned from travel to The People's Republic of China (Mainland China and Hong Kong Special Administrative Region), Singapore or Hanoi, Vietnam? If yes, identify city(s) country(ies) and date(s) of travel: _____

2. In the past 10 days, have you had close contact (lived with, cared for, had direct contact with respiratory secretions and body fluids) with any person who has recently returned from People's Republic of China (Mainland China and Hong Kong Special Administrative Region), Singapore or Hanoi, Vietnam? If yes, provide the person's name(s) and telephone number(s):

3. Since the onset of fever or cough, have you traveled to other USA cities? If yes, identify city(s) and dates of travel:_____

4. If you have traveled within t he U.S. while sick with cough or fever, identify method of transportation (air, bus, train, car, etc.): _____

5. Since the onset and fever or cough, have you: Yes ☐ No ☐
   (a) Worked in an office with other employees? Yes ☐ No ☐
   (b) Attended any social functions? Yes ☐ No ☐
   (c) Had contact with friends or family members not Living in your house? Yes ☐ No ☐

Over the past 10 days, have you had any of the following symptoms? (Check all that apply)

Symptoms	Yes	Symptoms	Yes
Fever		Trouble Breathing	
Shaking Chills		Sweating excessively	
Headache		Pain or tightness in the chest	
Dry cough		Very tired	
Sore Muscles		Pain in the stomach	
Sore Throat		Diarrhea	
Upset stomach (nausea)			

FAX THIS FORM TO:
County of Riverside Department of Public Health
Disease Control Branch

(951) 358-5102