Human Seoul Virus Exposure Questionnaire version 15 JAN 2017
(Please return to: _____)

Seoul Virus Human Assessment Form

DEMOGRAPHICS

Patient ID: _____

Facility Name: _____

Date of interview:_____

Name: _____ Sex: _____ DOB:_____ Age: _____
Last First MI

Address:_____
Street City/Town County State Zip

Phone number_____ Email address:_____

GENERAL RAT EXPOSURE QUESTIONS:

Do you wear gloves when handling rats? ☐ Sometimes ☐ Always ☐ Never

Do you wear gloves when handling rat bedding/droppings/urine/rat tubes? ☐ Sometimes ☐ Always ☐ Never

IF YES TO EITHER QUESTION ABOVE: What type of gloves do you wear when handling rats?
☐Latex/nitrile gloves ☐ Leather Gloves ☐Workman gloves ☐ Other specify: _____

Do you use hand sanitizer or soap/water after handling rats or their bedding/rat tubes?
☐ Sometimes ☐ Always ☐ Never

EXPOSURE TO RATS FROM A FACILITY WITH LABORATORY CONFIRMED SEOUL VIRUS INFECTIONS

Since **[effective date]**, have you had contact with a rat from a facility with laboratory confirmed infections of Seoul virus (in either humans or rats), including contact with the rat itself (such as petting, nuzzling, kissing), any rat caging, beddings, droppings, or urine? ☐ Yes ☐ No

IF YES: Please provide the following. (*Please list each contact event*)

Date of Contact	Setting (*e.g., pet store, rattery, rat party, barn hunt, at residence*)	Had physical contact with rat (Y/N)	Had physical contact with cage/ bedding/droppings/ urine (Y/N)	Comments (include names of establishments, nature of contact, etc.)

Form was completed by:_____
Name Affiliation phone/email

Patient ID: _____

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Since **[effective date]**, were you bitten or did you receive a tooth scratch by a rat acquired from a facility with laboratory confirmed Seoul virus infections? ☐Yes ☐No ☐Unknown

Since **[effective date]**, were you scratched by a rat from a facility with laboratory confirmed Seoul virus infections?
☐Yes ☐No ☐Unknown

Since **[effective date]**, Were you in contact with droppings/urine of a rat from a facility with laboratory confirmed Seoul virus infections (including cage cleaning, crate/transport cage cleaning, tube cleaning, etc.)?
☐Yes ☐No ☐Unknown

Since **[effective date]**, have other people had contact with your facility rat(s)/bedding/cage/droppings/urine (e.g. house guests, visitors, cleaning helpers)?
☐Yes ☐No

IF YES, Please list them below:

Name	Date of Contact	Telephone number	Nature of contact (*e.g. handling animals, cleaning cage etc.)*

Form was completed by:_____
Name Affiliation phone/email

Patient ID: _____

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EXPOSURE TO OTHER RATS

Since **[effective date]**, have you had contact with any rats **not** necessarily from a facility with laboratory confirmed Seoul virus infections (e.g from another rattery, a friend, at another gathering, etc)? ☐ Yes ☐ No
(Contact is defined physical contact with a rat, rat cage/bedding/droppings/urine)

15a. IF YES: Please provide the following. (*Please list each contact event*)

Date of Contact	Setting (*e.g., pet store, rattery, rat party, barn hunt, at residence*)	Had physical contact with rat (Y/N)	Had physical contact with cage/bedding/ droppings/urine (Y/N)	Comments (include names of establishments, contact information, nature of contact, etc.)

Form was completed by:_____
Name Affiliation phone/email

Patient ID: _____

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ILLNESS HISTORY

Have you experienced any illness since **[effective date]**, that required you to stay home from work/school or seek medical care? ☐YES ☐NO
(if yes, please complete the information about illness below)

Illness No.___:
Date of symptom onset:_____
Did you have any of the following?

Fever	☐Yes ☐No ☐Unknown	Malaise	☐Yes ☐No ☐Unknown
Muscle aches	☐Yes ☐No ☐Unknown	Headache	☐Yes ☐No ☐Unknown
Nausea/Vomiting	☐Yes ☐No ☐Unknown	Decreased appetite	☐Yes ☐No ☐Unknown
Abdominal pain	☐Yes ☐No ☐Unknown	Diarrhea	☐Yes ☐No ☐Unknown
Rash	☐Yes ☐No ☐Unknown	Sore throat	☐Yes ☐No ☐Unknown
Cough	☐Yes ☐No ☐Unknown	Red eyes	☐Yes ☐No ☐Unknown
Joint pain	☐Yes ☐No ☐Unknown	Blurred vision	☐Yes ☐No ☐Unknown
Eye pain	☐Yes ☐No ☐Unknown	Swelling in limbs	☐Yes ☐No ☐Unknown
Drowsiness	☐Yes ☐No ☐Unknown	Dizziness	☐Yes ☐No ☐Unknown
Chills	☐Yes ☐No ☐Unknown	Rash	☐Yes ☐No ☐Unknown
Bloody urine	☐Yes ☐No ☐Unknown	Foamy urine	☐Yes ☐No ☐Unknown
Shortness of breath	☐Yes ☐No ☐Unknown	Back pain	☐Yes ☐No ☐Unknown

Other symptoms not listed above_____

Did you seek medical care? ☐YES ☐NO

IF YES, please list each medical facility you visited

Medical Facility 1:_____Date:_____

Attending Doctor:_____ Diagnosis:_____

Medical Facility 2:_____Date:_____

Attending Doctor:_____ Diagnosis:_____

Medical Facility 3:_____Date:_____

Attending Doctor:_____ Diagnosis:_____

Were you hospitalized? ☐Yes ☐No ☐Unknown

IF YES, where were you hospitalized?

Medical Facility:_____ Dates of Hospitalization: _____

Attending Doctor:_____ Diagnosis:_____

Form was completed by:_____
Name Affiliation phone/email

Patient ID: _____