

Sleep Lab Travel Screening

Communicable Disease Screening

Have you been in contact with someone who was sick?

Yes	No/Unsure	Unable to assess
-----	-----------	------------------

If marked unable to assess, please explain: _____

Do you have any of the following symptoms?

- | | | |
|---|---|---|
| <input type="checkbox"/> None of these | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Red eye |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Rash | <input type="checkbox"/> Bruising or bleeding |
| <input type="checkbox"/> Muscle Pain | <input type="checkbox"/> Weakness | <input type="checkbox"/> Joint pain |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Severe headache |
| <input type="checkbox"/> Unable to assess | <input type="checkbox"/> Fever | |
-

Travel History

Have you traveled internationally in the last month?

Yes	No	Unable to assess
-----	----	------------------

If marked unable to assess, please explain: _____

If marked Yes, where? _____

