

H1N1 ADULT/ADOLESCENT QUESTIONNAIRE (PATIENTS OVER 12 YEARS OLD)

Please answer the following questions to determine if you need to be seen for the H1N1 Virus. Please answer **YES** or **NO** to the following questions:

Do you have a fever greater than 100.4?

Do you also have any of the following symptoms-nasal congestion, sore throat, or cough.

If you answered **YES** to the two questions above, please continue with the questionnaire.

If you answered **NO**, you probably do not have the H1N1 virus. If you start to develop these symptoms please re-take this questionnaire to determine if what level of care is required.

Section I: Please answer the following questions: Yes or No

Is it hard to breathe or do you feel short of breath since you got sick?

Since you have been sick, do you have a new pain or pressure in the chest, other than pain with coughing?

Do you have severe or persistent vomiting? Are you throwing up every time you drink something?

Are you confused, or experiencing sudden dizziness?

Have you had any seizures in the last 24 hours?

Have you urinated fewer than 3 times in the last 24 hours?

Did your flu like symptoms get better then return with the fever and cough?

If you answered **YES** to one or more questions above, your assessment risk is **ELEVATED**, please seek immediate care with the ER. Please bring this questionnaire with you to the ER.

If you answered **NO** to the questions above, please continue with this questionnaire.

Section 2: Do you have any of the following diseases/conditions: YES or NO

Lung diseases such as asthma, COPD, or cystic fibrosis Diabetes Pregnancy

Heart diseases such as heart failure, previous heart attacks Severely overweight

Received or completed chemotherapy in the last 30 days HIV/AIDS

Recently received an organ transplant Dialysis Brain or neuromuscular Diseases

<19 years old and on chronic aspirin therapy Age 65

Organ transplant recipient Liver disease such as cirrhosis Sickle cell disease

If you answered **YES** to any of the diseases/conditions, your assessment risk is **INTERMEDIATE**, please contact your PCM or get an appointment in your provider's clinic. Please bring this questionnaire with you to the clinic or tell the appointment line you took the questionnaire. If you answered **NO** to the above questions, your risk of complications due to a viral illness is low.

If you start to have any of the symptoms listed in SECTION 1, please go to the nearest ER.

If you have a fever, please stay home from work or school until you do not have a fever for at least 24 hours without the use of fever-reducing medicines such as Tylenol or Motrin. Keep well hydrated. Practice good hygiene such as coughing into your sleeve, washing your hands regularly, and wearing a mask around other people. You can also go to the CDC website at <http://www.cdc.gov/h1n1flu/sick.htm> for further information and guidance.

This questionnaire is designed to help you understand the flu symptoms you or your family member may be having so you can make your own health care decisions. It is not medical evaluation or treatment. If you believe you need to seek medical care, you should do so.