Form Approved
OMB No. 0920-1011
Exp Date 3/31/17

HEALTHCARE WORKER
RABIES EXPOSURE QUESTIONNAIRE

Last Name:_____ First Name: _____

Address: _____ Home Phone # (_____) _____
Work Phone# (_____) _____

City: _____ Zip Code: _____

5. Age _____ (years)

6. Sex: M F

7. In which department do you work? _____

8. What is your job title? _____

   Describe your job: _____

9. Did you have any physical contact with the patient, his bodily secretions, laboratory specimens, or tissue?

   No _____ Yes _____

   If NO, go to # 11

10. About how much time did you spend with the patient? _____ (hours)

11. Were you bitten by the patient? No _____ Yes _____

12. Were you kissed by the patient? No _____ Yes _____

13. Were you in contact with any of the patient's fluids or secretions listed below? (Check each selection that applies)

				If YES, was it on:	
				Bare Skin	Gloves, Etc.
1.	Saliva	No ___	Yes ___	_____	_____
2.	Respiratory secretions	No ___	Yes ___	_____	_____
3.	Cerebrospinal fluid	No ___	Yes ___	_____	_____
4.	Tears	No ___	Yes ___	_____	_____

14. Did you have a fresh wound, cut or other break in skin that may have been in contact with the patient's oral secretions?

   No _____ Yes_____

If YES: Location of wound/cut break _____
Which secretions?

1. Saliva _____
2. Respiratory secretions _____
3. Cerebrospinal fluid _____
4. Tears _____

15. Did any of the patient's oral secretions come in contact with your eyes, mouth, or nose (mucous membranes)?
No _____ Yes_____

If YES: Describe secretions, mucous membranes & circumstances.
_____

_____

_____

16. Did you participate in any procedure performed on the patient? (Include intubation, lumbar puncture, nasogastric tube insertion)
No _____ Yes_____

If YES: Which procedure: _____

What personal protective equipment did you use?
_____

Did you have any breaks in your gloves?
No _____ Yes_____

17. In your opinion, what was your most significant exposure? What was the exposure you are most concerned about?
_____

_____

_____

18. Have you previously been immunized against rabies?
No _____ Yes_____

If YES: When? (Month/Year) _____/_____

Why were you immunized? _____
Which vaccine? _____