**TEMPLATE PUBLIC HEALTH RISK ASSESSMENT – For travelers arriving the U.S. from Rwanda during the 2024 Marburg outbreak**

This document contains sample questions that can be used to assess the risk for Marburg virus exposure in travelers who have been in Rwanda during the past 21 days. Health department may customize their questions for their own use.

How to use these questions: Screen traveler for potential exposure using the initial screening questions. Ask the **additional public health assessment questions** if a traveler answers **YES** to any questions in this initial screening**.** Questions in the public health assessment may be tailored to the results of the initial screening.

**SCREENING QUESTIONS**

**Today or in the past 2 days:** have you had any of the following symptoms?  
Fever (100.4° F / 38° C or higher) or feeling feverish? **☐ Yes ☐** No  
Chills? **☐ Yes ☐** No  
New or unusual headache or body aches? **☐ Yes ☐** No  
Vomiting or diarrhea? **☐ Yes ☐** No

**In the last 21 days:**Were you present in any healthcare facility in the outbreak area  
(such as hospital, clinic, or saw a traditional healer)? **☐ Yes ☐** No

Did you provide health care to or have other interactions with patients? **☐** **Yes ☐** No   
Did you have any contact with or were you near a sick person? **☐** **Yes ☐** No

Did you come into contact with anyone's blood or other body fluids (such as vomit, saliva, feces, or urine)? **☐** **Yes ☐** No

Did you touch a dead body or attend a funeral? **☐** **Yes ☐** No

**ADDITIONAL PUBLIC HEALTH RISK ASSESSMENT QUESTIONS**

**Health Assessment (Complete if febrile/feverish, ill appearance, symptomatic reported)**  
Appears well? ☐ YES ☐ NO– if NO, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

Temperature measurement : \_\_\_\_\_\_\_\_\_\_\_\_(°C/°F) Method:\_\_\_\_\_\_\_\_\_\_\_\_\_

Signs/symptoms in the **past 2 days?** ☐ No symptoms reported

☐ Fever (≥100.4°F/38.0°C )– if YES, T-max: \_\_\_\_\_(C/F) Method: \_\_\_\_\_\_\_\_\_   
Date (mm/dd/yy): \_\_\_\_ /\_\_\_\_ /\_\_\_\_\_ Time:\_\_\_\_\_\_\_ AM/PM **(calculate using your POE’s time zone)**  
☐ Subjective Fever ☐ Chills ☐New/Unusual Fatigue ☐ New/Unusual Weakness   
☐ New/Unusual Headache ☐ New/Unusual Muscle Pains ☐ Loss of appetite  
☐ Cough/difficulty breathing/sore throat, other resp symptoms ☐ Chest pain   
☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Abdominal pain ☐ Unexplained bruising/bleeding   
☐ Skin rash [If yes, describe appearance and location(s)]:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Date of 1st symptom onset (mm/dd/yy): \_\_\_\_ /\_\_\_\_ /\_\_\_\_\_

Comments (include location of any pains):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Use of antipyretic medication(s) in past 2 days: ☐ YES ☐ NO  
(includes acetaminophen, paracetamol, aspirin, ibuprofen, systemic steroids, some cold remedies)  
Name of antipyretic: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose: \_\_\_\_\_\_\_ Hrs ago: \_\_\_\_\_\_ Purpose: \_\_\_\_\_\_\_\_\_\_\_\_\_

Name of antipyretic: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose: \_\_\_\_\_\_\_ Hrs ago: \_\_\_\_\_\_ Purpose: \_\_\_\_\_\_\_\_\_\_\_\_\_

Was malaria prophylaxis taken as prescribed? ☐ YES ☐ NO Name of antimalarial: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Complete this section if any presence in healthcare facility (HCF)/healthcare setting**  
Healthcare facility(ies) name(s) and location(s) in Rwanda visited or worked in (check here ☐ if none visited/worked in): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for presence in HCF (check all that apply): ☐ Patient care ☐ Laboratorian  
☐ Cleaning/laundry service ☐ Other nonclinical role (clerical, clergy, social work, meal service, administrative)   
☐ Patient ☐ Patient’s companion/visitor   
☐ Presence in patient care areas ☐ Presence in non-patient care areas only   
☐ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
Last day present in HCF (mm/dd/yy): \_\_\_\_ /\_\_\_\_/\_\_\_\_\_   
Traditional healer visit: ☐ Yes ☐ No - If yes, describe visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the traveler work in a U.S. healthcare facility? ☐ Yes ☐ No

**Complete this section if provided healthcare, contact/near a sick person, contact with blood/body fluids**The following questions apply to any setting (healthcare or non-healthcare):

Did you have any contact with blood or body fluids? ☐ YES ☐ NO

Did this involve any of the following? Check as applicable.

☐ Needlestick ☐ Other injury with a sharp object (that is, piercing of your skin) ☐ Skin contact

☐ Splash to the eye, nose, or mouth

Was the person suspected or known to have Marburg?

☐ YES SUSPECTED ☐ YES CONFIRMED ☐ UNSURE ☐ NO

Diagnosis other than Marburg if known:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Description: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you have contact with any sick person? ☐ YES ☐ UNSURE ☐ NO **If NO, section is complete.**

Did the person have fever? ☐ YES ☐ UNSURE ☐ NO

Did the sick person have vomiting, diarrhea, or bleeding? ☐ YES ☐ NO ☐ UNSURE  
Was the person suspected or known to have Marburg?

☐ YES SUSPECTED ☐ YES CONFIRMED ☐ UNSURE ☐ NO

Diagnosis other than Marburg if known:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you have physical contact with this person? ☐ YES ☐ UNSURE ☐ NO

Did you stay in the same household as this person? ☐ YES ☐ NO

Did you provide care to this person? ☐ YES ☐ NO

If YES to provided care:

Did you provide this care in a healthcare facility or another location (such as a home)?   
 ☐ HCF ☐ Home ☐ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Comments \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Healthcare workers only:

What personal protective equipment did you use? ☐ N/A  
☐ Surgical or medical mask ☐ Respirator (e.g., N95, KN95) ☐ Surgical hood ☐ PAPR   
☐ Disposable fluid-resistant or impermeable gown/coverall ☐ Disposable apron   
☐ Disposable full-face shield ☐ Goggles ☐ Waterproof rubber boots ☐ Boot covers   
Latex/nitrile gloves: ☐ One pair ☐ Two pairs (outward with extended cuffs)

☐ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
Did you perform hand hygiene after removing PPE? ☐ YES (every time) ☐ NO (not every time)

Did you experience any breach in infection control precautions?   
☐ YES ☐ UNSURE ☐ NO ☐ N/A

Did you participate in an invasive procedure or an aerosol-generating procedure?   
☐ YES ☐ UNSURE ☐ NO ☐ N/A  
Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Complete this section if worked as laboratorian**  
Did you handle clinical specimens? ☐ YES ☐ NO  
What PPE did you use? ☐ None

☐ Surgical or medical mask ☐ Respirator (e.g., N95, KN95) ☐ Surgical hood ☐ PAPR   
☐ Disposable fluid-resistant or impermeable gown/coverall ☐ Disposable apron   
☐ Disposable full-face shield ☐ Goggles ☐ Waterproof rubber boots ☐ Boot covers   
Latex/nitrile gloves: ☐ One pair ☐ Two pairs (outward with extended cuffs)

☐ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
Did you perform hand hygiene after removing PPE? ☐ YES (every time) ☐ NO (not every time)

Did you have a needlestick, other sharps injury (that is, piercing of your skin), or splash to the eye, nose, or mouth, or skin contact with blood or other body fluids of a person who had Marburg or may have had Marburg? ☐ YES ☐ UNSURE ☐ NO

Did you have any other contact with blood or body fluids? ☐ YES ☐ NO

Please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Complete if worked as a cleaner or doing laundry in HCF**  
What was your role in the healthcare facility? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you perform environmental cleaning in any patient care areas? ☐ YES ☐ NO  
Did you handle wet or soiled laundry? ☐ YES ☐ NOWhat protective equipment did you use? ☐ None

☐ Surgical or medical mask ☐ Respirator (e.g., N95, KN95)   
☐ Disposable fluid-resistant or impermeable gown/coverall ☐ Disposable apron   
☐ Disposable full-face shield ☐ Goggles ☐ Waterproof rubber boots ☐ Boot covers   
Latex/nitrile gloves: ☐ One pair ☐ Two pairs   
☐ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you wash hands after removing protective equipment? ☐ YES (every time) ☐ NO (not every time)

Did you get any body fluids on your skin or clothes? ☐ YES ☐ NO ☐ UNSURE

Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Complete this section if reported contact with dead body or attended a funeral or burial**  
Did you attend a funeral or burial? ☐ YES ☐ NO Did you touch a dead body? ☐ YES ☐ NO   
Please describe activities at funeral/burial or touching a dead body (touched deceased person’s garments, belongings or water used to wash body?): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was the cause of death known? ☐ YES ☐ NO If YES, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you serve as mortuary/burial worker? ☐ YES ☐ NO **If NO, go to Final Open Question.**  
**If a mortuary/burial worker**, what protective equipment did you use? ☐ None

☐ Surgical or medical mask ☐ Respirator (e.g., N95, KN95)   
☐ Disposable fluid-resistant or impermeable gown/coverall ☐ Disposable apron   
☐ Disposable full-face shield ☐ Goggles ☐ Waterproof rubber boots ☐ Boot covers   
Latex/nitrile gloves: ☐ One pair ☐ Two pairs (outward with extended cuffs)   
☐ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you wash hands after removing protective equipment? ☐ YES (every time) ☐ NO (not every time)

Did you have any problems with your protective equipment that resulted in your skin or clothes coming into contact with the dead body or body fluids? ☐ YES ☐ UNSURE ☐ NO

**FINAL OPEN QUESTION: (all travelers)**Any other situations that are of concern to you about your health that we haven’t raised?

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