



CO-MORBIDITIES/CLINICAL HISTORY –(BASELINE, NURSE LED)	
Known conditions diagnosed or existing before Ebola infection <input type="checkbox"/> Click here to mark all below as NO	
Chronic cardiac disease <input type="checkbox"/> NO <input type="checkbox"/> YES Specify: _____	Metastatic solid tumor <input type="checkbox"/> NO <input type="checkbox"/> YES Specify: _____
Chronic pulmonary disease (not asthma) <input type="checkbox"/> NO <input type="checkbox"/> YES Specify: _____	Any malignancy including leukaemia & lymphoma <input type="checkbox"/> NO <input type="checkbox"/> YES Specify: _____
Asthma (physician diagnosed) <input type="checkbox"/> NO <input type="checkbox"/> YES Specify: _____	AIDS / HIV <input type="checkbox"/> NO <input type="checkbox"/> YES Specify: _____
Renal disease <input type="checkbox"/> NO <input type="checkbox"/> YES Specify: _____	Obese (as defined by clinical staff) <input type="checkbox"/> NO <input type="checkbox"/> YES Specify: _____
Moderate or severe liver disease <input type="checkbox"/> NO <input type="checkbox"/> YES Specify: _____	Diabetes with chronic complications <input type="checkbox"/> NO <input type="checkbox"/> YES Specify: _____
Mild liver disease <input type="checkbox"/> NO <input type="checkbox"/> YES Specify: _____	Rheumatologic disease <input type="checkbox"/> NO <input type="checkbox"/> YES Specify: _____
Chronic neurological <input type="checkbox"/> NO <input type="checkbox"/> YES Specify: _____	Dementia <input type="checkbox"/> NO <input type="checkbox"/> YES Specify: _____
Hemiplegia or paraplegia <input type="checkbox"/> NO <input type="checkbox"/> YES Specify: _____	Psychiatric disease <input type="checkbox"/> NO <input type="checkbox"/> YES Specify: _____
Lassa <input type="checkbox"/> NO <input type="checkbox"/> YES Specify: _____	Other, Specify: _____ <input type="checkbox"/> NO <input type="checkbox"/> YES
Has the patient ever been diagnosed with tuberculosis (TB)? <input type="checkbox"/> YES <input type="checkbox"/> NO	
If Yes, Is the patient currently taking TB medication? <input type="checkbox"/> YES <input type="checkbox"/> NO	
If Yes, Has the patient ever completed a course of TB treatment? <input type="checkbox"/> YES <input type="checkbox"/> NO	