***POST*-Travel Quesionnaire**

Donor Number: _____438_____

1. Where did you travel to? ***Minnesota***_____

2. Duration of trip:

- Less than or equal to 7 days
- From 8 to 14 days [x]
- Greater than 14 days

3. Did you do any of the following activities during your trip? Check all that apply:

- Consume or use non-filtered water e.g. drinking, bathing, brushing teeth, washing food, etc.
- Remote backpacking or trekking
- Travel on a cruise ship
- Visit a farm or ranch
- Adventure travel e.g. hiking, climbing, safari, exploring caves, etc.
- Visit hospitals, healthcare facilities, nursing homes, long-term care facilities, etc.
- Medical procedure e.g. cosmetic procedure, laser eye surgery, etc.
- Other, please describe [x] - Dancing at a wedding, winning at croquet
- None of the above

4. Did you experience any of the following during your trip? Check all that apply:

- Insect bites e.g. mosquito, tick, bee, spider, etc.
- Fever
- Cold or flu symptoms (e.g. runny nose, sore throat, headaches, muscle pain, etc.)
- Diarrhea, vomiting, abdominal pain
- New sexual partner
- Need for new medication(s)
- Other, please describe
- None of the above [x]