

# TRICHINOSIS SURVEILLANCE CASE REPORT

Form Approved  
OMB NO. 0920-0009

**PERSONAL DATA**

<b>State Reporting:</b> <div style="border: 1px solid black; width: 40px; height: 20px; margin: 5px auto;"></div> State abbreviation	<b>First four letters of last name:</b> <div style="border: 1px solid black; width: 80px; height: 20px; margin: 5px auto;"></div>	<b>Age:</b> <div style="border: 1px solid black; width: 40px; height: 20px; margin: 5px auto;"></div>	<b>Sex:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>Date of birth:</b> <div style="display: flex; justify-content: space-around; margin: 5px 0;"> <div style="border: 1px solid black; width: 30px; height: 20px;"></div> <div style="border: 1px solid black; width: 30px; height: 20px;"></div> <div style="border: 1px solid black; width: 30px; height: 20px;"></div> </div> Mo Day Yr
<b>Race/Ethnicity:</b> <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> Unknown <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> White				
<b>County:</b>		<b>Physician's Name:</b>		<b>Physician's Phone:</b> <div style="display: flex; justify-content: space-around; margin: 5px 0;"> <div style="border: 1px solid black; width: 30px; height: 20px;"></div> <div style="border: 1px solid black; width: 30px; height: 20px;"></div> <div style="border: 1px solid black; width: 30px; height: 20px;"></div> </div>

**DIAGNOSTIC DATA**

<b>DATE OF ONSET OF ILLNESS:</b> <div style="display: flex; justify-content: space-around; margin: 5px 0;"> <div style="border: 1px solid black; width: 30px; height: 20px;"></div> <div style="border: 1px solid black; width: 30px; height: 20px;"></div> <div style="border: 1px solid black; width: 30px; height: 20px;"></div> </div> Mo Day Yr		<b>OUTCOME:</b> <input type="checkbox"/> Recovered <input type="checkbox"/> Died <input type="checkbox"/> Unknown		
<b>SIGNS AND SYMPTOMS:</b> <b>Eosinophilia:</b> <input type="checkbox"/> Yes <input type="checkbox"/> Not Done <input type="checkbox"/> No <input type="checkbox"/> Unknown Specify absolute number or percentage: (#) _____ or (%) _____		<b>Fever:</b> <input type="checkbox"/> Yes <input type="checkbox"/> Unknown <input type="checkbox"/> No Specify temperature: _____	<b>Periorbital edema:</b> <input type="checkbox"/> Yes <input type="checkbox"/> Unknown <input type="checkbox"/> No	<b>Myalgia:</b> <input type="checkbox"/> Yes <input type="checkbox"/> Unknown <input type="checkbox"/> No
<b>MUSCLE BIOPSY:</b> <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Done	<b>SEROLOGIC FINDINGS:</b> <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Done <input type="checkbox"/> Unknown Test type (specify): _____ Date of test: <div style="display: flex; justify-content: space-around; margin: 5px 0;"> <div style="border: 1px solid black; width: 30px; height: 20px;"></div> <div style="border: 1px solid black; width: 30px; height: 20px;"></div> <div style="border: 1px solid black; width: 30px; height: 20px;"></div> </div> Mo Day Yr Date of test: <div style="display: flex; justify-content: space-around; margin: 5px 0;"> <div style="border: 1px solid black; width: 30px; height: 20px;"></div> <div style="border: 1px solid black; width: 30px; height: 20px;"></div> <div style="border: 1px solid black; width: 30px; height: 20px;"></div> </div> Mo Day Yr Test results: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unequivocal <input type="checkbox"/> Unknown Test results: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unequivocal <input type="checkbox"/> Unknown			

**EPIDEMIOLOGIC DATA**

<b>SUSPECT FOOD:</b> <input type="checkbox"/> Pork (specify type below): <input type="checkbox"/> Store bought pork <input type="checkbox"/> Pork from farm-raised pig <input type="checkbox"/> Wild boar <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> Not specified <input type="checkbox"/> Non Pork (specify type below): <input type="checkbox"/> Bear meat <input type="checkbox"/> Hamburger (ground meat) <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> Not specified <input type="checkbox"/> Unknown		<b>DATE CONSUMED:</b> <div style="display: flex; justify-content: space-around; margin: 5px 0;"> <div style="border: 1px solid black; width: 30px; height: 20px;"></div> <div style="border: 1px solid black; width: 30px; height: 20px;"></div> <div style="border: 1px solid black; width: 30px; height: 20px;"></div> </div> Mo Day Yr
<b>WHERE MEAT OBTAINED:</b> <input type="checkbox"/> Supermarket/grocery store <input type="checkbox"/> Butcher shop <input type="checkbox"/> Restaurant or other public eating establishment <input type="checkbox"/> Direct from farm <input type="checkbox"/> Hunted or trapped <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> Unknown		<b>PREPARATION AFTER PURCHASE FURTHER PROCESSING:</b> <input type="checkbox"/> No further processing <input type="checkbox"/> Ground (i.e., hamburger) <input type="checkbox"/> Smoked <input type="checkbox"/> Dried jerky <input type="checkbox"/> Marinated <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> Unknown
<b>PATIENT'S OCCUPATION:</b>		<b>METHOD OF COOKING:</b> <input type="checkbox"/> Uncooked <input type="checkbox"/> Fried <input type="checkbox"/> Open-fire roasting/BBQ <input type="checkbox"/> Other cooking method (specify): _____ <input type="checkbox"/> Unknown
<b>RELATED CASES:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		<b>LARVAE IN SUSPECT FOOD:</b> <input type="checkbox"/> Not examined <input type="checkbox"/> Present <input type="checkbox"/> Absent <input type="checkbox"/> Unknown

**COMMENTS AND ADDITIONAL DATA**

Investigator name and title:

Date form completed:

Public reporting burden of this collection of information is estimated to average 20 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect

