

CYCLOSPORIASIS SURVEILLANCE CASE REPORT FORM

Form Approved
OMB NO. 0920-0009

Demographic Data:

Patient's name: Last First

State of residence: County:

Sex: Male Female Age: Date of birth (mm/dd/yy):

Race/Ethnicity (select one or more):

- American Indian or Alaska Native
Black or African American
Native Hawaiian or Other Pacific Islander
Asian
Hispanic or Latino
White
Unknown

Physician's Name: Phone:
Physician's Email:

Clinical Data: (NOTE: for dates, be as specific as possible. However, approximations (e.g., mm/yy) are okay.)

Date of illness onset (mm/dd/yy): Unknown

Signs and symptoms:

Diarrhea: Yes No Unknown Fatigue: Yes No Unknown
Maximum number stools per day: (unknown = 999)
Anorexia: Yes No Unknown
Nausea: Yes No Unknown
Weight loss: Yes No Unknown Vomiting: Yes No Unknown
Baseline weight: lbs. (unknown = 999) Abdominal cramps: Yes No Unknown
Number of pounds lost: Other symptoms (specify):
Fever: Yes No Unknown
Temperature (if measured): degrees F (unknown = 999)
Hospitalized (at least overnight): Yes No Unknown
If yes, list name of hospital: Date of admission:

Stool collection date: Results: Positive Negative Unknown

Confirmed by state lab? Yes No Unknown Confirmed by CDC lab? Yes No Unknown

Was the case-patient treated for cyclosporiasis? Yes No Unknown

If yes, what medication was provided? trimethoprim/sulfamethoxazole (e.g., Bactrim, Septra, Cotrim)
Other (specify): Unknown

Is case-patient sulfa-allergic? Yes No Unknown

Epidemiologic Data: (NOTE: for dates, be as specific as possible. However, approximations (e.g., mm/yy) are okay.)

Public reporting burden of this collection of information is estimated to average 15 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 of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-0009).

History of Travel (during the 2 weeks before onset of illness): Yes No Unknown

International travel (country): Unknown dates (**check here if dates are unknown**)

(1) _____ Departure date (mm/dd/yy) ___/___/___ Return date (mm/dd/yy) ___/___/___

(2) _____ Departure date (mm/dd/yy) ___/___/___ Return date (mm/dd/yy) ___/___/___

(3) _____ Departure date (mm/dd/yy) ___/___/___ Return date (mm/dd/yy) ___/___/___

Travel in the United States (state): Unknown dates (**check here if dates are unknown**)

(1) _____ Departure date (mm/dd/yy) ___/___/___ Return date (mm/dd/yy) ___/___/___

(2) _____ Departure date (mm/dd/yy) ___/___/___ Return date (mm/dd/yy) ___/___/___

(3) _____ Departure date (mm/dd/yy) ___/___/___ Return date (mm/dd/yy) ___/___/___

Exposures (during the 2 weeks before onset of illness):

Ate fresh berries: Yes (if yes, specify types below; check all that apply) No Unknown

Strawberries Blackberries Blueberries

Raspberries Black raspberries Golden raspberries Unknown type of berry

Other type of berry (specify): _____

Ate fresh herbs: Yes (if yes, specify types below; check all that apply) No Unknown

Cilantro Oregano Thyme Mint Dill Parsley Rosemary

Basil (specify types): Sweet basil Thai basil (i.e., green leaves and purple stems)

Purple basil (i.e., purple leaves and stems)

Other type of herb (specify): _____

Unknown type of herb

Ate lettuce: Yes (if yes, specify types below; check all that apply) No Unknown

Mesclun (a.k.a., spring mix, field greens, baby greens, & gourmet salad mix)

Arugula

Other type of lettuce (specify): _____

Unknown type of lettuce

Ate other types of fresh produce: Yes (if yes, specify types below; check all that apply) No Unknown

Fruit, other than berries (specify types): _____

Unknown type of fruit

Other type(s) of fresh produce (specify): _____

Unknown type of fresh produce

Did the case-patient attend any events (e.g., wedding reception) during the 2 weeks before symptom onset? Yes No Unknown

If yes, specify type of event: _____

Event date: ___/___/___

Does the case-patient know of any other ill persons? Yes No Unknown

If yes, did health department collect contact information about other ill persons and investigate further (provide comments below)?

Yes No Unknown

Comments and additional data:

Name (person filling out form): _____

Title: _____

Phone: _____ - _____ - _____ FAX: _____ - _____ - _____

Email: _____

Name of investigating health department: _____

Date form completed: ____/____/____

Revised 9/3/02